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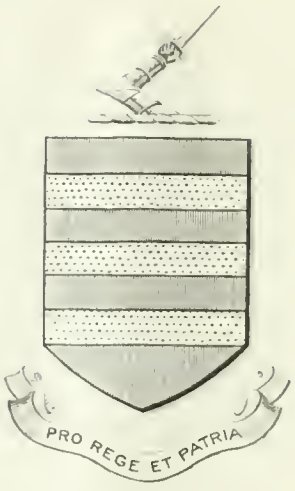

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

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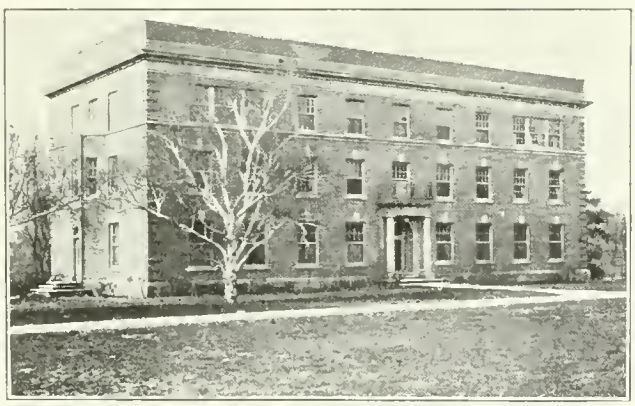
THE IOWA STATE COLLEGE HOSPITAL

By W. R. RAYMOND, Iowa State College Hospital, Ames, Iowa

THE Iowa State College of Agriculture and Mechanic Arts is in many respects an isolated educational community. The college campus is separated from the main business and residence section of the town of Ames by a distance of two miles, a part of which is through a section of low grazing and farm land. Hospital needs developed early. A small frame structure served for a time, a large brick structure, first used as a dormitory, was later taken over for the hospital. As the college population grew, a new and much larger structure became an imperative necessity. In 1915 the Iowa Legislature appropriated funds for a college hospital with modern equipment. In the summer of 1917 the work of erection was begun, and in the fall of 1918 the finished hospital as it appears in the accompanying photograph was opened to the college community. The cost of the building complete, with equipment, was approximately $60,000. During the two years since its completion, including the difficult war period when a large number of soldier-students were in training, the hospital has given splendid service to the student body.



View of the exterior of Iowa State College Hospital (from the northwest.)

The new hospital was designed by Proudfoot, Bird and Rawson, of Des Moines, Iowa, architects for the state board of education; and the building was erected by the superintendent of buildings of the college. The structure stands at the outer corner of the southwest rectangle of the college campus, sufficiently secluded, but close enough in to be of maximum service in emergency cases. It is ninety-six feet long, forty-six feet wide and three stories high. The outer walls are of red brick laid in Flemish bond, with trimmings of Bedford stone. The frontage is north. Groups of white birches and Russian olives stand to right and left of the north or main entrance, and flowering shrubs line the walls. Smaller side entrances give access to the building from east and west. On the east, a second side entrance leads first into the old hospital, which was left standing as an annex on the south, and from which access to the new building is gained through a closed corridor connecting the two buildings. From the windows, view may be had of Alumni Hall and the beautiful Central Building on the east, of Engineering Hall across a stretch of green to the north, of the big College Gymnasium and athletic field to the west, and of a campus residence park to the south; and beyond there are glimpses of more distant campus areas and buildings, and of the town and rolling, fertile country.

The interior of the hospital is both attractive in appearance and efficient in equipment and arrangement. The walls, which are of hollow tile construction with three coats of plaster, were finished at first chiefly in white, a recent refinishing

One of the wards.

of a portion of the interior was done in ivory and cream. The floors, which are of reinforced concrete and hollow tile construction, are laid in brown marble-effect terrazzo, with marble border. The woodwork is of well-seasoned birch, with white enamel finish. Doors are of solid slab birch, stained in mahogany, the width of the doors, throughout, is three feet. A half basement beneath the west end of the building contains storage rooms and a machine room for the electric elevator. On the first floor is carried on the work of consulting, dispensing, and minor treatment, and the preparing of food. The two upper floors are devoted chiefly to the care and treatment of bed patients. Each floor above the ground is divided longitudinally, east and west, by a corridor, which, in the two upper floors, is partitioned into three sections by Florentine glass paneled doors. All furniture and equipment was chosen and placed for appearance as well as for utility. High ceilings and numerous and spacious windows insure abundance of light and air. At night the indirect lighting system in use makes the hospital especially pleasing and restful.

Through the simple arched doorway, flanked by two plain white columns, the visitor enters the lobby and outside waiting room. At the left is a well-equipped dispensing room, enclosed in glass. Opening from the east corridor are the office of the college physician, a comfortable waiting room each for the men and the women, three small dressing rooms, and, adjoining the physician's office, a large consultation room. In this consultation apartment, which may be called the chief workroom of the hospital, the doctor and nurses meet and confer with their student patients and give them such first aid and office treatment as they may need. Of dispensary cases and cases requiring surgical dressings, nearly ten thousand pass through this room during a college year. From the lobby the west hall on this floor leads to the hospital kitchens. The preparation kitchen is equipped with gas cooking ranges, steam cookers, and other modern culinary fixtures, and there is telephone connection with the diet kitchens on the upper floors. The service kitchen adjoining has a large refrigerator, a room cupboard for dishes and food, and an electric food elevator also connecting with the diet kitchens above. Convenient to the passenger elevator, which opens upon the corridor, are a fumigating closet and a laundry collecting room. Across the hall are comfortable quarters for the cooks and the janitor, and a dining room for the physicians and nurses. From the south lobby the closed passageway, above referred to, leads to the hospital annex on the south, and a stairway and the electric elevator connect the main floor with the basement and the upper floors.

Opening from the east corridor of the second floor are five of the smaller hospital rooms, ranging from one to four beds each. This section is used for the college women. At the end of the women's corridor there is a bow-window alcove, furnished with easy chairs and table, for the special use of convalescent patients. A special feature of this floor is the room known as the par-

The waiting room.

ents' room, which opens on the central corridor and is fitted with modern conveniences, including long distance telephone. This room is frequently used by parents having very sick sons or daughters in the hospital. The west section of the second floor is devoted to the care of college men. South of the corridor in this section is a five-bed ward, complete with bath, which is especially designed for the care of contagious cases. Across the corridor are a single private room and another five-bed ward. Ample toilet and bath facilities are provided for the floor; a number of the rooms are privately equipped. Opening on the central corridor, besides the parents' room and the elevator, there are the chart room, the nurses' workroom, and the diet kitchen for the floor. The diet kitchen, which is accessible through double-acting doors from both the central and west corridors, is equipped with closet trays, cupboard for dishes, a small refrigerator, gas plate for heating food, suitable sinks for washing dishes, and the food elevator and telephone connections with the main kitchens before mentioned.

In the chart room and the nurses' workroom the activities of the floor center. There is a desk for the floor nurse, with both outside and inside telephone connections; here are made and kept the individual records, or charts, of the patients on that floor; here also centers the signal light and call system. By means of this light and call system, which deserves special mention, a patient from his bed may put himself into instant connection with every part of the hospital. An electric button lies within his reach, with light, call, and release adjustments. At the first pressing of the button red lights appear above the door of his room, one inside (for his own assurance) and one outside in full view from the chart room

A private room.

and the length of the corridor. At the same time other lights, all of a single color to indicate the floor from which the call comes, appear on all the other floors; in the chart rooms of both the upper floors, in the doctor's office and the dispensary on the first floor, and in the operating room on the third floor. If this light signal is not answered, a second pressing of the button by the patient releases buzzer calls on all floors, while the lights remain burning. A third pressing of the button, after the coming of the nurse or attendant, puts out all the lights. The system is simple and effective in its working, and makes possible temporary shifts and reductions of the hospital force with no consequent neglect of the patients.

In general arrangement—division of corridor, location of diet kitchen, chart room, nurses' workroom, signal system, division into men's and women's sections, etc.—the third floor is much like the second floor. The chief differences are in the east section. The east corridor has been shortened nearly half, and three rooms for general hospital service occupy the entire width of the building. The shortened corridor opens on the right into the x-ray room; on the left into the operating room; and at the end into the sterilizing room. In the x-ray room, a large and conveniently arranged apartment, is installed a William Meyer x-ray ma-

The dispensing room.

First floor plan.

chine with all accessories, including a dark room for developing plates. The sterilizing room, between the x-ray and operating rooms, has walls of buff glazed brick; the ceiling is light in color. The equipment of the room consists of high-pressure steam sterilizer, a gas incinerator, metal table, and supply cupboard.

The operating room is perhaps the best equipped and most attractive apartment in the hospital. The ceiling of this room is of solid cement, painted with white enamel. The side walls, to the height of six and one-half feet, are finished in moss-green vitrified tile, the portion above in white enamel to correspond with the ceiling. The woodwork is green enamel, the floor is terrazzo finish. The lighting facilities are as nearly perfect as they could be made. Daylight is admitted by three large windows in the north wall and a skylight nine by nine feet. For night work and accessory lighting on dark days there are arranged around the skylight sixteen one-hundred candle power nitrogen lamps with blue-tint bulbs and x-ray reflectors, and four powerful indirect lighting fixtures at the corners. The artificial lighting approaches daylight effect; the system was used by a graduate engineering student of the college as the subject for his Master's thesis. The operating equipment of the room is complete and up to date. Visiting physicians and surgeons of Iowa and from outside the state have congratulated the hospital authorities upon the appearance, convenience, and equipment of their operating room.

The main operating room.

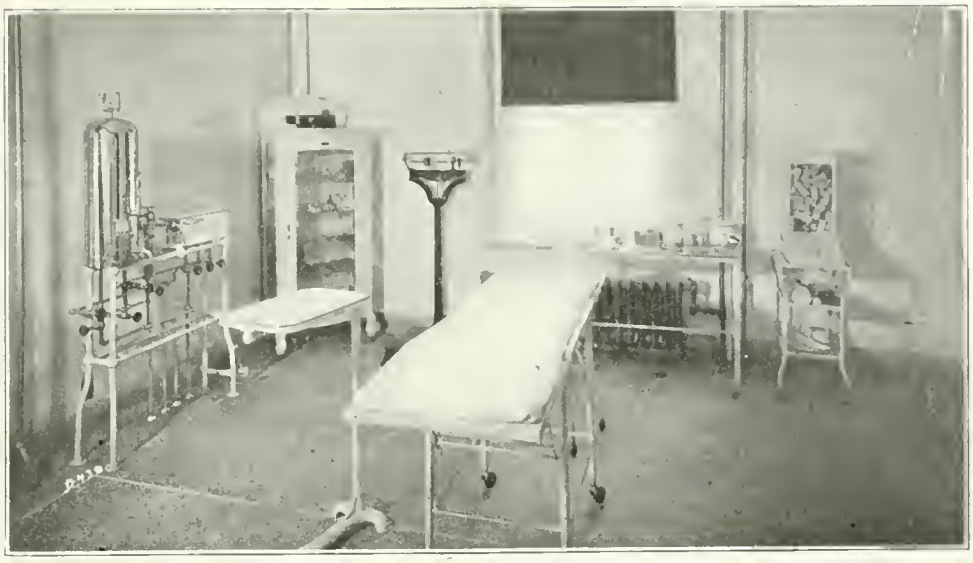
The construction and material equipment of the hospital throughout are of the best. During the planning and erecting of the building, and in the selection of equipment, leading experts of Iowa and other states were freely consulted. The cost of the building complete, with equipment, came out of state funds, but the expense of new equipment and of maintenance, including salaries, is taken care of by a hospital fund created by student fees.

The privileges of the hospital are extended to all students. Each student pays at the opening of each quarter an incidental fee, of which two dollars are credited to this hospital fund. Under this arrangement, which practically amounts to health insurance for the college population, the student is entitled to consultations, examinations, medicines, and dressings. If he becomes seriously ill and is taken to the hospital, he is charged an additional $1.25 per day for the first three weeks and $1.50 thereafter as long as he remains in the hospital. These charges, which are based upon probable actual costs, are made to defray the expenses of general nursing, board, heat, light, and laundry. As costs vary, the charges for service are changed from time to time, and no surpluses are allowed to accumulate. While the college assumes no liability beyond the extent of the fund so created, it does give a maximum of service at very reasonable rates.

In the administration of the hospital plan no obligation, of course, is placed upon the student to avail himself of the hospital service provided. He is as free to consult outside physicians and to secure outside accommodations and attendance in case of injury or sickness as if he were not connected with the college. But the reports of the college physician show that the great majority of the students appreciate the hospital privileges and freely seek hospital advice and attention when in need.

The hospital service was referred to earlier

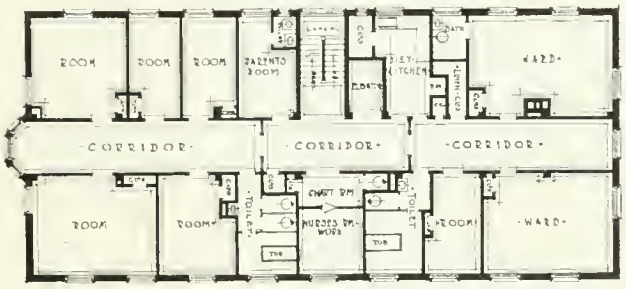
in this article as health insurance. Through the cooperation of other departments of the college, this insurance is strengthened and extended. The college physician is chairman of the public health committee of the college faculty. A thorough physical examination of men entering the institution is made by the physical training department. A similar provision will be made for women. Vaccination certificates may be required of students entering for the first time. The college physician is authorized to exclude from college dormitories and recitation rooms any person having a contagious disease. Through cooperation with the city health officers, he may also see that necessary quarantine regulations are applied to student rooming and boarding houses beyond the campus limits. Close relationships are maintained between the hospital authorities and the various deans' offices of the college. In this way much is done to help the student whose college work suffers because he is sick. Through this cooperation, also, the student is likely to receive more of the sympathy and personal attention of his instructors than he might otherwise get in so large an institution. In the preparation of food for bed patients in the hospital, there is hearty cooperation with the dietetics specialists of the home economics division of the college. Thus every effort is made, through measures of prevention as well as of direct service, to reduce sickness and disease to a minimum in the college community.



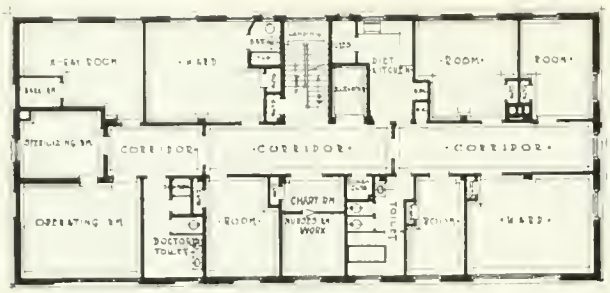
The small operating and dressing room.

The capacity of the new hospital is forty-five beds; of the annex, eighteen beds. The staff consists of the college physician, Dr. Charles G. Tilden, who devotes full time to hospital service, a consulting physician, five graduate nurses, three student assistants, a competent cook, and a cook's assistant.

What the presence of the college hospital on the campus at Ames means to the college community is best shown, perhaps, by a glance at the statistical summary in the latest report of the college physician. Since 1916 (exclusive of 1918-1919, the year of the war, when no records of these cases were kept) the average annual number of office cases, in which dispensary and minor surgical service was given, has been nearly 10,000. Bed cases during the same period (including 1918-1919) were nearly 1,000 per year. Already the hospital is at times crowded to its limits of space and capacity for service; and as the college grows such periods are becoming more and more frequent. In a recent statement about the hospital, the president of the college, Dr. Raymond A. Pearson, called attention to its advantages in a somewhat isolated academic community like the Iowa State College. "In the numerous shops and laboratories about the campus," he said, "which are connected with the divisions of engineering, industrial science, agriculture, veterinary medicine, and home economics, accidents are not infrequent. In the college hospital the resulting injuries—most of them, fortunately, not serious—can be given skilled emergency treatment. Then, too, prompt and skillful attention to cases of sickness—sickness often contracted before the students leave home—means not only relief for the sick students, but protection also for the large community of well ones. A third fact, perhaps more important than the other two, is that the hospital service, together with the health lectures of the college, is teaching the students how to care for their own ailments and injuries, when to consult



Second floor plan.



Third floor plan.

a physician, and especially to contract the habit of consulting one instead of allowing unhealthful bodily conditions to become chronic; in short, teaching the secrets of health conservation as applied both to themselves and to the communities in which later they will be workers and citizens."

MINNEAPOLIS GENERAL OFFERS POST-GRADUATE WORK IN ANESTHESIA

A course which is offered at the Minneapolis General Hospital, Minneapolis, Minn., is open only to graduate physicians and dentists and is conducted throughout the entire year. It covers a period of two weeks, during which the student is taught all forms of practical anesthesia by means of lectures, demonstrations, and practical application daily of the didactic teaching in dental, surgical and obstetrical anesthesia.

Classes are limited to six students, thus permitting each student to receive personal attention and obtain the maximum benefit from the course.

Each course continues a minimum time of two weeks, thus insuring the student of adequate preparation for conducting proper anesthesia.

All types of general anesthesia are taught. The course majors in nitrous oxide-oxygen and ether anesthesia, but the use of ethyl chlorid, chloroform, and other anesthetic agents wil be considered. The object of the course is to produce anesthetists not dependent upon any single type of anesthetic agent, method, or apparatus.

The use of standard apparatus, illustrated and described, and the technique of each apparatus, will be taught clinically. The variety of the clinical material received at this institution is exceptionally good for teaching purposes.

An extremely low fee of fifty dollars is charged for each course of two weeks. Students desiring to continue further instruction may do so by arrangement with the faculty, at the rate of twenty-five dollars per week. A six months' scholarship is open to students who have finished the course in the Minneapolis General Hospital, with free tuition and maintenance in the hospital.

Reservations for entrance must be made in advance. The limited size of the classes makes registration in advance necessary. Final application must be accompanied by payment in full for the course.

The faculty consists of: J. A. Heidbrink, D.D.S., dental anesthesia; A. E. Guedel, M.D., surgical anesthesia.

For further information address: Dr. Walter E. List, superintendent, Minneapolis General Hospital, Minneapolis, Minn.

"The commercially minded nurse can never get from her profession the finer satisfactions in store for the nurse who lives by the higher ideals of service."—Higgins.

DOWLING MEMORIAL COMMITTEE ANNOUNCED

In memory of the late Michael J. Dowling, of Olivia, Minn., who was handicapped by the loss of his limbs except for one arm minus the hand, but who in spite of this led such an inspiring and useful life, the Minnesota Editorial Association has started a movement to erect a memorial home. At a meeting held recently at the University Farm, the Association unanimously decided that President Philip Liesch, of New Ulm, should appoint a committee of ten members, one from each congressional district, with J. R. Landy, of Olivia, as chairman and director-in-chief, which is to serve as a Dowling Memorial Committee, and which is authorized to direct a drive for funds for the erection of a $100,000 memorial home for crippled children, as Mr. Dowling had taken an active interest in their welfare. The Dowling School for Crippled Children in Minneapolis was named in his honor several years ago.

The committee appointed by President Liesch, and the districts which they represent, is as follows: first, E. K. Whiting, Owatonna; second, A. M. Welles, Worthington; third, O. J. Quane, St. Peter; fourth, Harrison Fuller, St. Paul; fifth, George Akerson, Minneapolis; sixth, Asa M. Wallace, Sauk Center; seventh, Ludwig Roe, Montevideo; eighth, W. H. Hassing, Carlton; ninth, H. M. Wheelock, Fergus Falls; tenth, M. S. Norelius, Lindstrom.

The editors throughout the state will act as local committeemen. The plan for the drive proposes to work in cooperation with the Minnesota Bankers' Association, Benevolent and Protective Order of Elks, American Legion posts, and other organizations. It has not yet been determined whether the memorial will be located in Minneapolis, St. Paul, or elsewhere.

MENTAL DEFICIENCY A SERIOUS PROBLEM

"The prevention and correction of mental defectiveness," says the United States Public Health Service, "is one of the great public health problems of today. Its influence is continually cropping out. For instance, recent studies have shown that feeblemindedness is an important factor in prostitution, and that a marked proportion of juvenile delinquency is traceable to some degree of mental deficiency in the offender.

"A recent state-wide survey in Oregon shows that more than 75,000 men, women, and children out of a total population of 783,000 are dependents, delinquents, or feebleminded, and that more than 500 school children out of a total enrolled school population of 32,500 are more or less mentally deficient. The latter fact is significant when it is remembered that the condition of the children of today is the best possible index to the condition of the community of tomorrow.

"The Oregon figures are considerably lower than the average shown by the draft examination, indicating that they are certainly not higher than those that would be obtained in other states."

POOR AND RICH BRAINS

A valuable contribution to medical science has been made by Dr. R———, who died Wednesday, in willing his brain to Prof. Wilder, head of the medical department of Cornell.

Dr. R——— was actuated by a desire to further study of the cerebrum. The majority of specimens obtained are from almshouses, with little consequent value.—*Cleveland Plain Dealer.*

ORGANIZATION AND MANAGEMENT OF HOSPITAL WARDS IN STATE HOSPITALS

By EDWARD A. FOLEY, M.D., Assistant Managing Officer, Chicago State Hospital, Dunning, Ill.

In the light of the knowledge and experience achieved in psychiatry during the war, reorganization in the administrative, medical, and surgical services of the state hospitals for the insane is deemed urgent. Reclassification of services, intensive sub-grouping, proper segregation, careful supervision, and expert nursing service are essential in the scientific care of mental patients. A diagnostic department, and well-equipped hospital and surgical units should be established.

An analysis of the needs for and functions of the various services, and a feasible solution of the problems met in the care of the insane, are given in this timely article by an experienced administrator.

In state hospitals for the insane, the various divisions of service have, as a rule, been loosely considered. Usually these divisions are as follows: first, the receiving; second, the custodial; and third, the hospital service. Lately, closer attention has been given to housing conditions and behavior of the insane; also to the possibilities and means of making them more comfortable. Consequently, reclassification of the various services is strongly recommended. What has formerly been designated the receiving service, can now be changed to the diagnostic department. In this division the new arrivals are to be cared for, together with readmitted cases returning from parole and escape. The second group of wards, formerly termed custodial, will be better known as education and industrial wards. This group can be divided according to behavior into the irritable and non-irritable types, again into workers and non-workers. The hospital division must be divided into wards for medical and surgical patients and for the infirm. The patients in the latter department are a distinct class from those admitted to the hospital service. Owing to the modern tendency to intensive sub-grouping, this classification naturally results. Proper segregation cannot be without its good influence, as far as the hospital is concerned.

To be a success, the hospital department must be a unit in itself, the number of beds in this unit to be determined by the size of the institution. Given a state hospital with a capacity of three thousand patients, one hundred twenty-five beds should be allotted to the hospital. With five thousand patients, the hospital can be increased to two hundred beds. A building of two stories with elevator service will be found to be the most convenient. To each patient must be allowed at least eight hundred cubic feet of air.

In order to care for each sex as comfortably as possible, the building should be so constructed that, though the sexes are separated, the employees can go with ease from one department to another in the least possible time. To each sex, two wards should be given over; one large ward containing thirty-five beds for medical cases, and one smaller ward of ten beds for the cases needing surgical care. In connection with the medical wards, five rooms of one bed each should be included, which can be used for contagious diseases or for relatives visiting patients who are seriously ill. The remaining twenty-five beds should be placed at the disposal of employees, three or four of which should be in single rooms to be used in isolating contagions.

The question will probably be raised: Why so many beds for employees? In answer—the fact must not be lost sight of that epidemics are apt to occur at any time. Frequently I have seen the hospital management at a loss to know how they are going to care for sick employees. This anxiety was always due to the lack of sufficient bed space given over to nurses, attendants, etc.

Well Equipped Surgical Unit Necessary

No hospital can be considered complete without a well equipped surgical unit. The unit should include operating, dressing, and sterilizing rooms, besides one for anesthetizing. Separate from the surgical suite, the hospital should have a room in which emergency cases of minor importance are given attention. Among the insane, injuries occur quite frequently in the wards where the more irritable type of patients are confined. These minor wounds may have to be attended to many times during the day. In the same room, septic cases can be looked after. Here should be equipment for sterilization of dressings and surgical material. The hospital must have a complete x-ray department large enough to permit all x-ray work to be done. A dark room for developing, and room for exhibition of plates must be included. Owing to the difficulty in dealing

with insane patients, diagnoses of fractures are more or less uncertain. Many times a fracture might not be discovered were it not for this diagnostic aid. Not only this, but in restless patients, dressings are frequently removed by them, making retreatment necessary.

In proximity to the wards given over to medical cases, should be located the diet kitchen; also a room containing medical supplies. All wards should be constructed so that toilets, wash rooms, and bath rooms are easily accessible to ambulatory patients. An oversight in most hospital plans is the provision for rooms for the clothes of bed patients. These rooms, if included, are usually put in some out-of-the-way place, or makeshift. They should, however, be so constructed as to be spacious enough to care for the clothing not only of the bed-patients but for those who are convalescing. The rooms should also be well lighted and ventilated.

The hospital department must be reserved for hospital cases in their true sense. Those suffering from physical illness and surgical cases only should be admitted. While the above conditions would be idealistic, one must realize in dealing with the insane that considerable latitude must exist when classifying the cases for the hospital. Sometimes an advanced case of paresis may receive a fractured rib. Such a case had better be cared for in the hospital than in one of the infirmary wards. Many unknown conditions are apt to develop in such cases that require careful nursing. Stretcher cases will often be brought into the institution from outside. These cases should be admitted to the hospital department until they are examined mentally and physically. If their infirmity is not due to some acute illness, they should be transferred to the ward especially set apart for them.

Medical ward in the hospital building of the Chicago State Hospital.

The nursing problem in a hospital department is highly important and should receive special attention. The unit should be directly under the charge of the chief nurse of the institution. Care must be used in selecting the head of the nursing department. Not only must she be a woman well trained in psychiatric nursing, medicine, and surgery, but she must have tact and be free from petty jealousies. A chief nurse must in a sense be a very broad minded woman. When a hospital department has such a one at its head, greater efficiency results in the nursing staff, and consequently the patients are better cared for. Under the chief nurse should be the charge nurses. With the eight-hour work day in force, one nurse should be in charge of each shift. The training of the charge nurses should be equal to that of the chief. In this position if common sense and tactfulness are not used with brains, lack of harmony and inefficient care of the patients results. The duty of the charge nurse is first of all to see that all orders of the physicians are carried out. In addition she should give proper supervision to the diets of all patients in the hospital. The economic side of hospital life must be a part of her life. A charge nurse who does not see that the bed linen and clothing of a patient is kept in a state of repair, is of little value. Far better to have linen patched than full of holes. In this connection the old saying "A stitch in time saves nine" applies.

True, one cannot expect the charge nurse on each shift to do all this alone. A graduate nurse whose training has been so complete that she could step in and take charge when the head nurse is sick or off duty should be in charge of each ward. In time, this ward charge should have under her a competent corps of assistants. These assistants should be pupil nurses in training, the number depending upon the size of the ward. For a thirty-five bed ward, at least two pupils should be assigned. The charting of temperature, general care of patients, and hygiene should be a part of their service—all this, of course, to be supervised by the ward nurse. For the household duties, the ward nurse should have under her jurisdiction a head attendant with an assistant who should be responsible to the ward nurse for all household cares.

Among the nurses on duty in the hospital, there should be considerable latitude regarding their services in the department. Under no circumstances should nurses or attendants assigned to the hospital be sent to other parts of the institution for duty. Damage to the patient and great inefficiency have resulted from this practice and from bringing "green" attendants for relief on the hospital service. In the first place, they are unfamiliar with the patients and conditions,

secondly the patients cannot get the attention they are entitled to. The charge nurse should have her assistants so trained that all will be ready to take charge of the operating room when an emergency comes up. She should also see that the operating room is always ready. When instructed that an operation is to take place at such and such a time, she should see that instruments and suture material are properly prepared. Her practice and competency should leave no doubt in the mind of the operator but that all will be right.

An important point in dealing with the sick insane is to see that they are carefully supervised at meal time. The meals for the employees should be scheduled so they all can be present while the patients are eating. This is important to avoid trouble of all kinds. I do not think it advisable to have up-patients feed those in bed.

Many patients are sent to the hospital wards because they are poorly nourished. One cannot depend on patient help when the matter of nutritives are at stake. Trained help is necessary to see that a well balanced ration is administered to hospital cases. The charge nurses should be well schooled in dietetics.

For other duties such as assisting in the household, convalescent patients can be used. I say convalescent patients, instead of permanent ward workers. Too frequently I have seen nurses and attendants working patients ten, twelve, and sixteen hours when they themselves would grumble if asked to work more than eight. So, in the hospital it is better to utilize the convalescing patients and change them frequently. Occupation is good for the insane as well as the sane. When the condition of the bed patient permits it, the condition will improve with various forms of bedside occupations such as the bed-loom, basket weaving, or the rake knitting. Cooperation between physicians, nurses and attendants and patients must exist to bring forth the best results. Cooperation spells efficiency. Where there is no unity, failures occur. The management of the hospital department must be a unit. When there are too many heads, it brings inefficiency on the part of the nursing staff, and neglect of the patients. All connected with the hospital must realize that the patient comes first and personal or petty matters should be relegated to the back ground during hours on duty.

PLACING PATIENTS

When a patient is to be sent out of an institution, it is important that the social service department of that institution ascertain whether he has sufficient income for himself and his dependents. If not, the department should be able to place him in a position where he can make a living, and to this end should keep in touch with firms and organizations where employment might be found.

NEW PUBLIC HEALTH SERVICE HOSPITALS

The hospital program of the United States Public Health Service is moving rapidly. Nine new hospitals, which will accommodate more than 3,000 patients, are now being put into shape for early occupancy. Three of these, in Iowa, Montana, and Oregon, with a capacity for about five hundred patients, should be in operation within two months. Others will not be ready for a longer time. Especially will this be the case with three army reservations, two of which had been abandoned for ten to twenty months, which were specifically transferred to the Service by Act of Congress.

The Colfax Hotel, at Colfax, Iowa, a leased building with 130 acres of grounds, is being fitted to receive 200 patients. The army hospital at Fort William Henry Harrison, near Helena, Mont., will be opened with 100 general beds, but may later be greatly expanded. Additional money will be necessary to fit the buildings at Dawson Springs, near Hopkinsville, Ky., for maximum usefulness; but the necessary funds are expected to be forthcoming and the hospital to be opened with 500 beds for tuberculosis patients within five months. The Hahnemann Hospital, at Portland, Ore., should be ready for 164 general patients by July 1, and the Speedway Hospital, at Chicago, for 1,000 general patients by August 1.

Of the three army posts specifically turned over by Congress, that at Fort Walla Walla is attractively situated near Walla Walla, Wash., on a low plateau near the junction of the fruit and wheat belts. The post has been abandoned for a year and, except for two brick barracks, its buildings are in bad condition and must be rebuilt. It will shelter 284 tuberculosis patients.

Fort McKenzie, one mile northwest of Sheridan, Wyo. is pleasantly situated against a northern shield of mountains. Its brick buildings surround a fine parade ground, once planted with trees, which, however, have suffered severely from lack of irrigation since the post was abandoned. Most of the region is sparsely timbered.

The red brick buildings of Fort Logan H. Roots, near Little Rock, Ark., stand on a bluff overlooking the Arkansas River. During the war some temporary wooden buildings were erected, but most of these have been removed.

Forts McKenzie and Roots are each planned to accommodate more than 600 nervous mental cases. Each of the three posts may be ready in less than six months.

A naval station at Gulfport, Miss., has just been taken over from the navy by the Public Health Service, and will be utilized as a hospital or home either by the Service or by some other branch of the government.

SPECIAL PROVISION FOR CATHOLIC SISTERS

The American Hospital Association announces that, at its conference at West Baden, the rooms for Catholic Sisters will be grouped in one section of the hotel, and one of the smaller dining rooms will be set aside for their exclusive use. There is a Catholic church on the hotel grounds, and Father Manning lives in the hotel. Practically all the guests at the hotel will be hospital people, and the Association feels that the Sisters as well as the other delegates will enjoy the social, as well as the more serious side, of the conference.

"If every hospital or asylum included in its medical staff a musical director, and if every physician and trained nurse understood the nature of the action of music, there is no telling the good that might be accomplished, the lives brightened, and the tangled brains restored to harmony."—Egbert Guernsey, M.D.

A THIRTEENTH CENTURY HOSPITAL

By DOROTHY LOUISE MACKAY, M.A., San Francisco, Cal.

ON THE north side of "La Cité," which island in the thirteenth century comprised a large part of the city of Paris, was located the Hôtel-Dieu, most famous of medieval hospitals. It was, if we may credit a very widely accepted tradition, founded in the year 660, by Saint-Landry, twenty-eighth Bishop of Paris. He had it built next to the Church of Saint-Christophe, where it was to be a house of refuge for the poor, the sick, and infirm, as well as a shelter for travelers and pilgrims. From the medieval period down to the present day, it has played a very important part in history, not only as an item of medical interest, but as a phase in the social development of the ages.

While the majority of medieval hospitals consisted of but one main room and a few out-buildings, the Hôtel-Dieu of Paris comprised a complete and extensive system. During the latter half of the twelfth century it had been rebuilt and situated on the north bank of the Seine between the Cathedral of Notre-Dame and the Petit-Pont. This location was both desirable and interesting. The wing near the Petit-Pont opened on a very busy section of the city. Past it ran the Rue de Marché Palu, where the food dealers and pharmacists sold their wares. Parallel to the hospital and the river extended the Rue Neuve de Notre-Dame, the rendezvous of scribes, illuminators, goldsmiths, and engravers, forming the principal thoroughfare of the neighborhood.

The site was a healthful one, and the best that the city afforded. In spite of the fact that the opposite bank of the river was occupied by meat dealers and fishermen, the resulting odors could be tolerated because of the many other advantages. The streets of a medieval city were anything but pleasant because of the lack of sewers. For this reason, the Hôtel-Dieu was favored in having the river on one side for drainage, and an infrequently used street on the other.

The buildings had the appearance of a church, the Gothic style predominating. Part of the house extended out over the river and was supported by pillars placed in the water. The space between these pillars was converted into vaults and cellars. The level of the rooms was well above that of highest water, and only the lower parts were affected by floods.

There were four main wards and several annexes. The ceilings were high, the average being eighteen to twenty-five feet. The roofs were arched, and this plan was continued in the intersecting arches of the stained glass windows. An ingenious system of pulleys and cords provided excellent ventilation, and assisted in the regulation of the temperature. Heat was provided in each ward by means of charcoal stoves with chimneys.

The wards were partitioned off into a series of cell-like enclosures by screens or wainscoting, a practice still surviving in many French hospitals. Around the whitewashed walls, and above the partitions, ran a gallery from which persons on duty could obtain a complete view of all patients without disturbing them by entering their rooms. Thus we see that the building plan of the Hôtel-Dieu was one in which the details, as well as the main features, were very carefully worked out.

During the medieval period, the hospital was conducted in connection with the Cathedral of Notre-Dame. The chapter enforced rules, and conducted or supervised all important business transactions. It was also responsible for the finances, which were drawn from many sources. Most important were the legacies and gifts of patients and their friends, and prominent and pious persons; donations, immunities, and privileges granted by the King; the estates of the hospital in and near Paris, from which a considerable income was obtained.

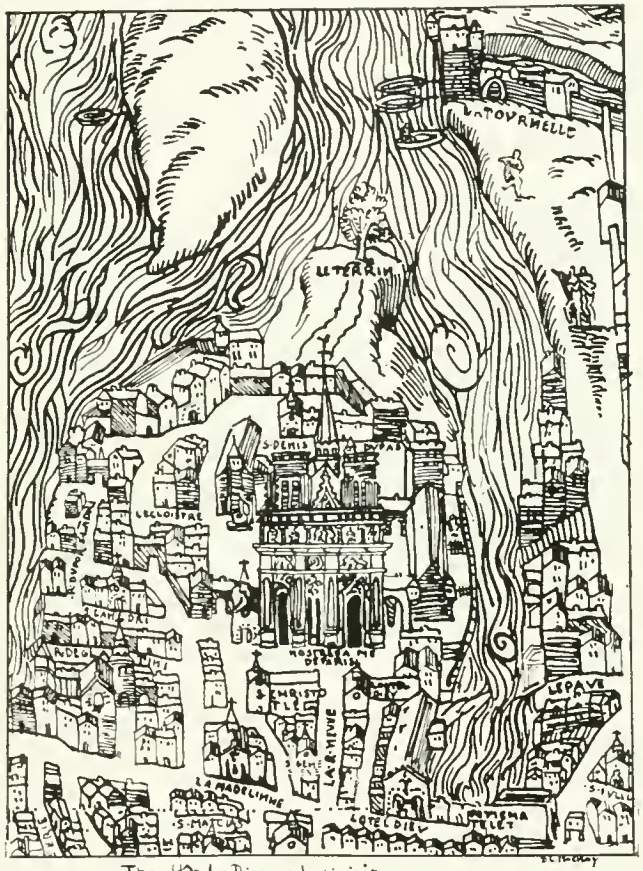
The administration and work of the hospital was conducted by a monastic community, the members following the manner of living of the Augustinians. Their number was fixed by the statutes formulated about the year 1220, from which we learn that there were thirty lay brothers, four clerical brothers, four priests, and twenty-five sisters. There were also a number of apprentices who were preparing for admission.

The male members of the community usually entered as choir boys at the age of seven or thereabouts, and "took the habit" between the years of eighteen and twenty-five. Following this, a considerable period was spent in the more menial work, after which they were promoted to administrative positions according to their abilities and fitness. These offices included not only posts as heads of departments within the hospital, but also the collection of rents, and the administration of the external estates. Some of the brothers preferred religious duties, and studied for holy orders, becoming later the spiritual officers of the institution.

The sisters entered between the ages of ten and twenty, as "filles blanches," or apprentices.

Between the years of eighteen and twenty-five, they were usually allowed to take their vows as sisters. When a vacancy occurred, one of the apprentices was selected by the Chapter for admission. She was given the veil at the solemn service at Notre-Dame, after which she entered upon her year of probation under the guidance and tutelage of an old and highly revered sister.

The community was supervised by a commission of two or four provisors, appointed by the Chapter of Notre-Dame to oversee the business, inspect the administration, management, and work of the hospital and its several departments. In addition to this, a formal inspection of the entire hospital took place on the twenty-eighth of December and at Pentecost. The Chapter, the provisors, and all the members of the staff not necessarily occupied, proceeded on a tour of the hospital. They visited each ward and department, and the members of the Chapter inquired into conditions. Then, after a religious service, reports were made concerning the affairs of the house and the conduct of the personnel. Suggestions, admonitions, and reprimands were given at this time. This control of the hospital by an administrative board strikes an exceedingly modern note, for in it we are reminded of the method of administration in such institutions today.



The Hôtel-Dieu and vicinity.
Reproduced from a facsimile of a map of Paris during the reign of Henry III. (Lindenau et Hagen, Plan de Paris, etc. Reproduit en fac-simile d'après l'original conservé dans la bibliothèque de l'hôtel-de-ville de Cöln)

Within the hospital itself the prior was supreme. He was usually selected from among the brothers of the community, but such a choice was not compulsory. In addition to the general supervision of the house, he had personal charge of six departments, namely the household, kitchen, chapel, cellar, baths, and charity-box,—all those in which the brothers worked.

The prior and members of the board chose a prioress, who was next in authority after him. She had entire charge of the female members of the community, and of the departments in which they worked. These included the care of the sick, and the service of the linen-room, locker-room, and laundry.

Each department of hospital work was presided over by an "officier," or chief. He was assisted by specially assigned members of the order, or by external assistants or servants, who were hired when necessary.

The baking was done by a master baker and two assistants, who were usually members of the brotherhood. The chief was responsible not only for the quality and quantity of the output, but for all arrangements for the selection and purchase of materials. Both white and brown bread were made four times a week, but this did not constitute the entire supply, as gifts of bread were regularly made to the hospital.

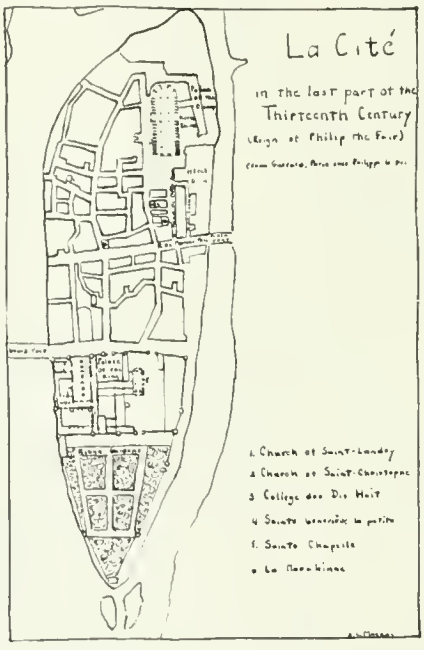
The staff of the kitchen was quite large. The chief, like the chief of the bakery, was not only responsible for the cooking, but for the selection and purchase of materials. In this man we have the predecessor of the modern dietitian. He did none of the cooking himself, for his work was entirely administrative and theoretical. He arranged purchases, and planned the meals for patients and staff. Each day a list of the former was sent to him, that he might calculate the amount and kinds of diets. He directed his assistants in the cooking and apportioning of the food, and was supervisor of all food processes.

Closely allied with this department was that presided over by the cellarer, a brother who had become expert in the process of winemaking. He had charge of all that was made and used in the institution, and of the vault in which it was kept.

A very important service in the Hôtel-Dieu was the linen-room, where all the cloth used in the institution was provided. Four sisters were kept continually busy making and repairing clothing, bed-linen, mattresses, bed-covers, and other necessities. All their materials, again, were purchased direct. Merchants on their way to

Paris stopped there to display their goods, and in addition, the prioress and assistants made regular trips out into the city to replenish the supplies. This department handled annually three thousand elles of heavy cloth, forty to fifty pounds of linen, fifty to eighty of toweling, and about forty elles of goods for covers. They also used sixty elles of some very coarse material, and from fifty to eighty pounds of yarn. Five to seven hundred sheets were made annually.

No less important was the laundry, which was located in one of the cellars of the house, and which opened out upon the Seine. In it worked nine sisters and six or more apprentices. This was considered the easiest work in the hospital, and was the first duty assigned to a girl upon entrance. About nine hundred pieces were washed each time. The assistants went to the river early in the morning to prepare the work. In winter they did this by the light of lanterns, and even at times found it necessary to break the ice in order to reach water. They were soon followed by the others, and the morning was spent in soaking the clothes. Two days later they went back and washed them thoroughly. The drying was done on the island, or if weather prevented, in the linen-room or corridors of the hospital.



Conditions were not very favorable for this work. The waters of the Seine were frequently very uncertain, and the small branch of the river sometimes ran so low that the sisters had to go over to the island of Saint-Louis, or to that of Notre-Dame to wash. On other occasions there were floods, with resulting inconvenience, the cellar becoming filled, so that the laundry work had to be done in some other part of the house.

With the exception of the care of the sick, the field of the most common and numerous occupations has been covered. There were several others, such as shoe-making, tailoring, and auxiliary departments, usually occupying one person each.

Not only those engaged in nursing, but all members, were entering a life profession. All became specialists in their work, being allowed no responsibility until after years of training under supervision. In the field of nursing, which, because of the absence of the great discoveries of modern science, could not be as highly specialized then as today, a longer period of thorough training was required. From five to eight years were spent in menial work. Then began the first year of attendance upon the sick, which was one of probation, under close supervision. It was at least six years, and usually longer, before a girl was given the responsibility of unsupervised work. The training was carefully systematized. Before entering the order and the service of the sick, the nurse had passed through all departments in order of their difficulty.

Rules governing the life of members were very strict. Vows of poverty, chastity, and obedience were required of all, and infractions were severely punished. Only actual crime was punished by excommunication. Members who failed to fulfill the promise of poverty were required to do forty days of penance, during which time they ate from the ground, and were given only bread and water, except on Sunday. Infringement of some rules brought reprimand of corporal punishment. Most penalties were imposed at a weekly meeting of the entire community, when matters concerning its welfare were discussed. Attendance upon religious services was compulsory, and all must pray at stated hours.

Adequate provision was made for members who fell sick, or who were too old to perform their duties. There was a special sick-room provided for them, and they were attended with all possible care and reverence, for the statutes instructed that they be "sympathetically cared for."

Twice each day the bell summoned brothers and sisters to their respective refectories, presided over by the prior and prioress. The tables were covered with cloths, and set with individual dishes, a practice far in advance of private custom of the time. Service was supervised by one of the members who ate either before or after the others in company with the person assigned to read the scripture lesson during the meal. Although the prior and prioress regulated the portions served, the statutes made certain provisions as to the composition of the diet. Meat was served on Sundays, Tuesdays, Thursdays, and on certain religious holidays, including Christmas. A liter of wine was provided for each brother, while a sister received one "chopine," or about

a pint. The prior and prioress received double portion.

The apprentices slept in large common dormitories, but the members had small, plainly furnished rooms. Silence was enforced in the sleeping quarters, disturbers being punished by deprivation of the wine ration for the following day.

The costume of the members was specified in great detail. With slight differences appropriate to the time and work, it resembled the uniform of the members of the modern Roman Church. All clothing was provided in the house, and members were held strictly accountable for its care. New articles could be had only by producing the old for exchange.

The patients admitted to the hospital may be roughly grouped into four classes, the aged, the sick, the poor, and the pensioners. The first three require no description. They were admitted and cared for entirely without cost. The pensioners were persons who desired to live at the hospital, but who were neither patients, in a strict sense, nor members of the order. They were received under a contract with the prior, making a money payment for their board and lodging, or rendering some service, such as work on the estates of the hospital.

A Ward in the Hôtel-Dieu of Paris.
Fac-simile of a wood-engraving at the head of a sixteenth century manuscript. Reproduced from Fleetwood, Paris à travers les âges, I.

To gain admission it was only necessary for a person, except of course the pensioners, to present himself at the door, where he was received by a sister. He confessed his sins, took communion, and was then placed in a ward according to the apparent seriousness of his condition.

A modern locker-room had its medieval counterpart in the Hôtel-Dieu. The clothes of all patients were taken in charge by the sisters in this room. They had them laundered, and packed them away until the departure of the patient, who then received them in better condition than he had left them. If he died, they were sold, unless called for by his relatives within a reasonable time.

In the Salle Saint-Denis, which contained eighty beds, were placed the less serious cases. The infirmary, with its fifty-four beds, was reserved for those dangerously ill. Convalescents went to the Salle Saint-Thomas, where there were sixty beds. Although women as well as men were admitted to all wards, there was one known as the Salle, or Salle Jaune, for women alone. It contained eighty beds. In accordance with the custom of the time, of placing several persons in one bed, the Hôtel-Dieu permitted two in one bed, but never more.

There was special provision for pregnant women. A ward of twenty-four beds was constructed for them below, and as an annex to the Salle Neuve, where they were protected from the gaze and interruption of the casual visitor, and where they would not disturb others.

In most cases a bed occupied an individual enclosure. It consisted of a mattress of straw, supported on a network of ropes. The patient reclined in the bed unclothed, with covers placed over him. A pillow of feathers or twisted cloth was provided for his head.

We gather, from references in the statutes, that three sisters were on duty in each ward during the day, and one sister and two assistants at night. When they came on at six in the morning, they passed through the wards and put out the lamps. After bathing the face and hands of each patient, they made the beds. Those who were able, got up while this was in progress. Others were carried to another bed for the time. While the sisters were thus engaged, the servants did the cleaning.

Food was served twice a day. The rules specified that the patients should be served before the staff, a practice which apparently survives still. Each patient had his own dishes, including a wooden plate and a spoon.

As with the staff, meat was served them three times a week, and on holidays. Beef was the most common meat, but on holidays the menu was varied by pork and mutton. Fowl, soup, eggs, fish, and fruits such as figs, raisins, apples, and pears appeared regularly. Meals were well balanced, for the substitutes were served on meatless days. They had wine with each meal, and each ward received three pints of milk weekly. The regular diet was specified, but those who were very ill were tempted with delicacies. The wine ration for these was larger and they had more fowl. If they desired any special dishes, the statutes provided that it be provided if possible, unless it were injurious.

The patients often enjoyed special luxuries furnished by interested persons on gala occasions.

Sometimes a person left a legacy and a provision in his will that on his birthday the patients be given some particular luxury, or their choice of some delicacy. An authority says that no instance has ever been found of a complaint about the quantity or quality of the food served during the whole medieval period.

Visitors were admitted at any time, but came most frequently to spend the afternoon. Their gifts and many kindnesses brought much pleasure to the sick. After they left, about six o'clock, supper was served by the day nurses, who were relieved by the night shift an hour later. The entire hospital was then locked and business ceased.

The Hôtel-Dieu was especially favored among its contemporaries in having a medical and surgical staff. Both professions had just reached a degree of specialization in Paris which enabled them to organize and license their members. Obstetrics was never practiced by these men, but was left entirely to experienced midwives. During the thirteenth century, a midwife and her apprentice were attached to the service of the hospital. We also find agreements and contracts made with physicians and surgeons, by the terms of which they were to attend the patients in the Hôtel-Dieu.

The care of the sick was comparatively simple. Victims of plague, leprosy, and other widely feared contagious diseases were isolated.

Emphasis was laid on natural treatments rather than on the extensive use of herbs and drugs. Purgatives were freely prescribed, both medicines and fruits being used for that purpose. Baths and exercise were usually prescribed to follow.

While baths were not considered necessary in that day, the Hôtel-Dieu provided them for their therapeutic value. It owned two large bath-tubs built on wheels, which were moved from ward to ward. The sisters brought water from the kitchen in two large kettles and filled the tubs. The patient was plunged in. Afterwards he was wrapped in a drying-gown to prevent a cold.

A patient whose condition was deemed serious was observed closely. Upon the first appearance of death agonies he was removed from the ward to a bed where the priest administered the last sacraments.

The death rate during the early period was very low, and most of the patients seem to have recovered. When a person was considered well enough to go home, the doctor gave him a permit to leave. The patient usually preferred to remain a week or more after this time, to help the nurses with the ward work.

Since the Hôtel-Dieu was conducted under the auspices of the church, great attention was paid to the religious needs of the sick. Priests and clerical brothers performed regular services for them. They visited the sick, confessed them, administered sacraments to the dying, conducted funerals, made and executed wills.

The entire atmosphere of the Hôtel-Dieu was a beautiful one, an ideal of service, as if this service were being rendered to the Master himself. Is it strange that such a splendid work still survives, after more than twelve centuries, and still with its medieval name, this well designated "House of God"?

A Brother in the Hôtel-Dieu

CHANNELS OF PUBLICITY OPEN TO HOSPITALS

"The channels of publicity open to a local hospital or home, whether it be for the regular or general publicity, or for campaign publicity, are: The newspaper, the institutional monthly paper, annual reports, booklets and leaflets, occasional bulletins, personal and circular letters, lantern slide lectures, moving pictures, personal presentation, pulpit presentation, local church societies, use of special days, the annual and district conferences, and area gatherings."—RALPH WELLES KEELER, Director of Publicity of the Methodist Episcopal Hospitals and Homes.

PURCHASING FOOD FOR HOSPITALS

By HERBERT O. COLLINS, M.D., Director of Hospitals for Fresno County, Fresno, California

IN A previous article some mention was made of the advantages of purchasing certain articles of food in large quantities and storing them in root cellars or cold storage rooms. To what extent it is best to do this, and which products should be bought in comparatively small quantities on the open market, will depend upon the size and location of the hospital, and the facilities for buying and storing. No general rule can be laid down, but each hospital should study its own problems and decide for itself, having in mind the general principle that it is cheaper, as a rule, to buy in rather large quantities, provided proper means for preservation are available.

The same may be said with reference to the question as to who shall do the buying. In the very large hospitals the purchase of the food products is usually in the hands of an experienced purchasing agent, whose duty it is to keep in touch with the markets, who should be a good judge of qualities, and be held responsible for the character of the products purchased and for the prices paid. This centralizes the responsibility and gives the hospital the advantage of expert service. In hospitals of medium size, not large enough to require the full time of a purchasing agent, the same result can be obtained if some one officer can assume such duties along with other things. In the smaller institutions the duty of buying food supplies is often assumed by the superintendent or dietitian, or by both. Whichever plan is adopted, it will be found best to specifically designate one person for the work of buying, and he or she should be one whose judgment is good, and who has the time to keep posted on the conditions of the local market.

If the dietitian has had sufficient experience, she can help a great deal in connection with the purchase of food products, and should be encouraged to do so. In many hospitals she personally buys all perishable fruits and vegetables, especially those which must be selected from day to day as they become available in the market. Only in this way can she make out her menus and diets intelligently, or give her patients the benefit of market conditions as they exist. For it will often be found advantageous or even necessary to make slight changes in a preconceived menu, due to market conditions which cannot always be anticipated even a day ahead. This applies especially to the earlier fruits and vegetables as they first appear on the market.

Those who are familiar with hospital complaints realize that many times the fault found by patients is with the food, or with the way in which it is served. The popularity of the hospital may be either favorably or unfavorably affected through this department more quickly than any other, with the possible exception of the nursing service. Hospitals will find much room for improvement in this line, and it is well worth our time to give it serious attention.

If the chief dietitian is to assume full responsibility for the food service, have charge of all the kitchens, dining rooms, and special diet kitchens and tray service, she should not only be well grounded in the scientific principles of her profession, but should also be a woman of experience, executive ability and judgment in ordering and buying. This cannot all be obtained in schools of dietetics. Before she assumes such responsibilities, therefore, she should have served some time as an assistant in a good hospital. Many hospitals will find it advantageous to elevate the position considerably above its present status, if the food service is to be made more satisfactory.

ARTICLE: Sugar, Granulated. Maximum 2,000 lbs. Minimum 200 lbs.

Received		Issued		In
Date	Am't.	Date	Am't.	Stock

Fig. I. A perpetual inventory system for the food of the hospital.

Little advance in such a direction can be expected as long as hospitals, through false ideas of economy, continue to offer salaries which can only result in attracting to such positions young, inexperienced women, fresh from schools of dietetics, with little practical experience in managing so important a department, in selecting and buying food products, or in handling help. Nor can a hospital expect to attract the services of competent experts in dietetics, in which the dietitian is not only paid a salary which in many cases is less than that demanded by the head cook, but in which she is further handicapped by being a part of the training school organization, with a rank little, if any, above that of a head nurse in charge

*This is the fifth of a series of articles by Dr. Collins on the hospital food service, which is appearing in THE MODERN HOSPITAL.

of a ward, and in no position to take the initiative in the development of her department. As responsibility constantly tends to develop efficiency, provided it is built on a safe foundation, the dietitian should be the head of her department, responsible directly to the superintendent, ranking with other department heads in the hospital organization, and she should receive a salary suitable to command the services and respect of a woman who has spent some years in acquiring an important profession. This is already done in many of our best hospitals. But it is not till it becomes a common practice that the science of hospital dietetics will acquire the importance it deserves, or that our hospital food service can be placed upon a higher plane.

It will be found advisable to keep a close account of the quantities of food products purchased, balanced with the amount issued from the storerooms and that left in stock, as well as a record of the prices paid from time to time. Such a system is useful, not only for the purpose of holding the storekeeper responsible for goods delivered to his care, but it will also prevent the annoying situation produced by finding the stock of certain articles unexpectedly exhausted, because someone has forgotten to replenish it. A perpetual inventory system, such as is indicated in the form shown in Figure 1, will accomplish this. A separate card or sheet is kept for each article, and receipts and issuance of the article, with the amount remaining in stock, are entered daily from the requisitions. A glance at the card will always show the amount on hand, leaving the storekeeper no excuse for running short. As a further convenience, an arbitrary standard of the proper quantity of each article to be carried may be entered in one corner of the card, showing the amount that experience has proven to be the most convenient maximum quantity to carry at a time, and also the minimum amount it is safe to carry in stock. When the storekeeper finds his stock on hand, as shown by his inventory card, is approaching too near the minimum indicated on the card, he should make a requisition for the purchase of the quantity necessary to bring the stock to "maximum," and send it to the purchasing agent. The quantity asked for by the storekeeper, however, should be considered as only suggestive, and subject to change by the purchasing agent, according to his judgment, based on conditions as he finds them on the market.

Date.....192....

PURCHASING AGENT:

Please purchase the articles listed below, for use in the General Store Room.

Signed: .....Storekeeper

Articles	Am't. asked	Am't. ordered	Unit Price	Firm

Approved: .....Sup't.

The above articles have been ordered of the firms and in quantities as listed.

Signed: .....Purchasing Agent

Fig. 2. Form for a convenient ordering of food supplies.

Date.....192....

STOREKEEPER: Please deliver the articles listed below to .....

Signed.....

Approved..... .....Dietitian.

Article	Am't. asked	Am't. issued	Cost

The above articles have been received in good condition.

Signed.....

Fig. 3. A requisition slip showing the amount of food ordered for a certain kitchen, and the amount delivered.

A convenient method of ordering the purchase of food supplies is shown by the form indicated in Figure 2. This is made out by the storekeeper, and includes his statement of the amount he thinks should be purchased. After the purchasing agent has placed the order, the requisition, on which he has entered the quantity ordered, the price and the name of the firm with which he placed the order, is returned to the storekeeper, in order that he may know what quantity should be delivered, and for his use in checking the bills. Some hospitals prefer not to enter the price on the requisition. The storekeeper then checks the bills only to show that he has received the goods in good condition, leaving it for the purchasing agent to approve the bill as to the prices charged.

A reliable system is necessary under which food products may be ordered from the storekeeper, for use in the various kitchens and dining rooms, and it should include provision for the signing of a receipt for the goods delivered, by the person receiving them. One such requisition is shown in Figure 3. The two columns headed, respectively, "Amount Requested" and "Amount Issued" are desirable, as the storekeeper may not always be able to deliver the full amount requested. It will also be found desirable to fill in the cost or value of the article delivered, partly to help impress upon the cooks and others the need of economy, especially for the more expensive foods, and to form the basis for a cost accounting system if such is kept by the hospital.

LEGENDARY HISTORY OF WEST BADEN *

TO ALL who are interested in historical things, West Baden Springs, the convention center of the American Hospital Association for September, 1921, presents a field of most unusual study. With its wild and rugged topography it early attracted hardy and adventurous people, and its peculiar health-giving qualities made it worth a struggle to hold. The unusual natural formations of subterranean passages, caves, and streams, with groups of animal life which have adapted themselves to their strange environment, have offered, since earliest days, a never-ending source of wonder and investigation.

In striking contrast to stretches of adjacent territory, this region was, in early days, heavily timbered, with acres of forest trees of huge size, practically all of which have now been felled. Yet even today, in the stillness and isolation of the valley, it is not difficult to go back in imagination to the days when herds of deer and buffaloes roved here and there in careless ease. And then we may picture the coming of the white man, when the astonished deer hastened away through the woody thickets, and the buffaloes scattered in wild alarm, to herd again in distant places.

The bridge over Lost River.

The first record of the springs of West Baden is found in the memoirs of General George Rogers Clark, who, in recounting his famous expedition in Kaskaskia and Vincennes in the latter part of the eighteenth century, mentions, with high praise, the valuable waters which he found. From this time on tales of this region have been handed down with a safe degree of authenticity—but earlier legends, dating back into an age when facts and fancy are almost inseparable, still cling with a well grounded foundation of truth to romantic glens and grottos.

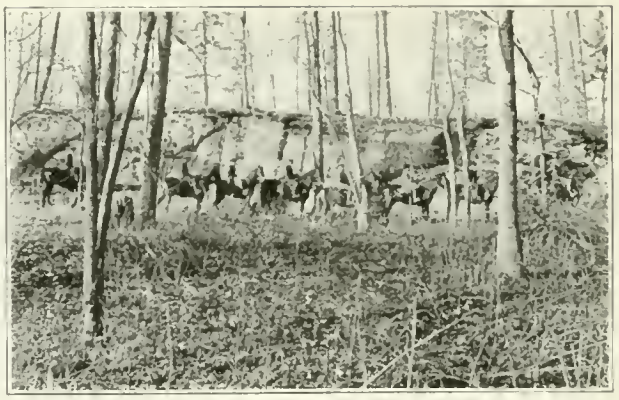
According to the tales told by the Indian to early settlers who came in after the Clarke expedition, there was established here for a time a community of Frenchmen who occupied this site coincident with or very soon after the settlement at Vincennes. Frequent encounters took place between the French and Indians, for this valley, with its lick springs, was a veritable happy hunting ground for the red men. Resistance on the part of the French, who were without available reinforcements, could not long be maintained, and they fled just in time to escape total annihilation. But before they left, so the story runs, they buried great treasures of silver, deep within the springs, knowing that overnight they would be so blackened by the sulphur waters that they could not be distinguished from the rocks in the bed of the gushing streams. Again and again, as these stories became known to later comers, search was made for the valuable treasures, but if they were buried in the springs their secret has been kept until today.

Although but one permanent Indian village, the village of Shawnee, was ever located in the immediate vicinity, a number of Indian camps are known to have been in existence within a radius of a few miles. Deer and other animals of the woodland sought these springs in great numbers and many and bitter were the conflicts between the rival tribes for the rights of possession of this beautiful valley. The medical properties of the waters were well known to the Indians of this section, and it is said they frequently gathered here for their weird medicine dance, while their medicine men conjured with the enchanted springs.

But even before the tribes of Indians, which later became known to the pioneers, lived here, a great settlement of Mound Builders dwelt near by. Many mounds, filled with interesting relics of this mysterious age, are found in the vicinity. The largest fortifications of these ancient people which have been discovered in any section of the state were about seven miles from here, near Paoli. This fortification consisted of two embankments, from twelve to thirty feet apart, and nearly thirteen hundred feet in length. The most plausible explanation of this fortification is that it was used for protection in time of battle and to ward off the encroachments of wild animals in times of peace. There is little doubt that it was inhabited as a village, though the indications are

*In order to give delegates to the forthcoming convention of the American Hospital Association a background for their visit to West Baden Springs, THE MODERN HOSPITAL announces the publication of a series of three articles on West Baden Springs, of which this is the first. The next article will tell how the West Baden Springs Hotel was used as a hospital during the World War.

A nearby fresh-water spring.



The bridle trail to Turkey Point, one of the attractive "high spots"

that the surplus population must have dwelt on the adjacent fields, resorting to the protection of the walls only in times of danger. Fishing implements, stone axes, arrow and spear heads, a large amount of pottery and many personal ornaments have been found. A huge burial mound also was opened near here some years ago, yielding many human skeletons, with their customary burial array of ornaments and implements.

Miami, Weas, and Piankeshaws were the most powerful tribes of Indians inhabiting this section, although at the time of the coming of the white settlers, Delawares, Pickapoos, Wyandots, and Shawnees were found. Four separate treaties and dates are recorded conveying in different tracts the land that is now included in this county. These treaties were made at Fort Wayne on June 7, 1803; at Vincennes, August 18, 1804, at Grouceland, August 21, 1805; and at Fort Wayne, September 30, 1809. One of the earliest traditions of the Shawnees was that the first white woman that was ever brought into the state was carried here a captive by the chief of the Shawnees, who, amid great ceremonies, took her for his wife.

No community is complete without its "ha'nt," and the spirit of the springs valley has roamed these wild woodland trails, it is said, since the year 1813. In the spring of that year a man by the name of William Charles was killed and scalped by the Indians not far from his home and within view of his wife, who was awaiting his return to their little cabin. His wife rushed to him, but her reason gave way at the terrific sight which met her eyes, and a few months later she died of a broken heart. Through the days that she lived in anguish after her husband's death, she constantly bewailed his suffering and wore at all times the hat which he had on at the time of his fiendish murder. Through this period of more than a century, the story of the Widow Charles has been handed down, and even today you may hear whispers that her spirit has been seen out among the hills, searching, calling for her husband, his blood-stained hat upon her head.

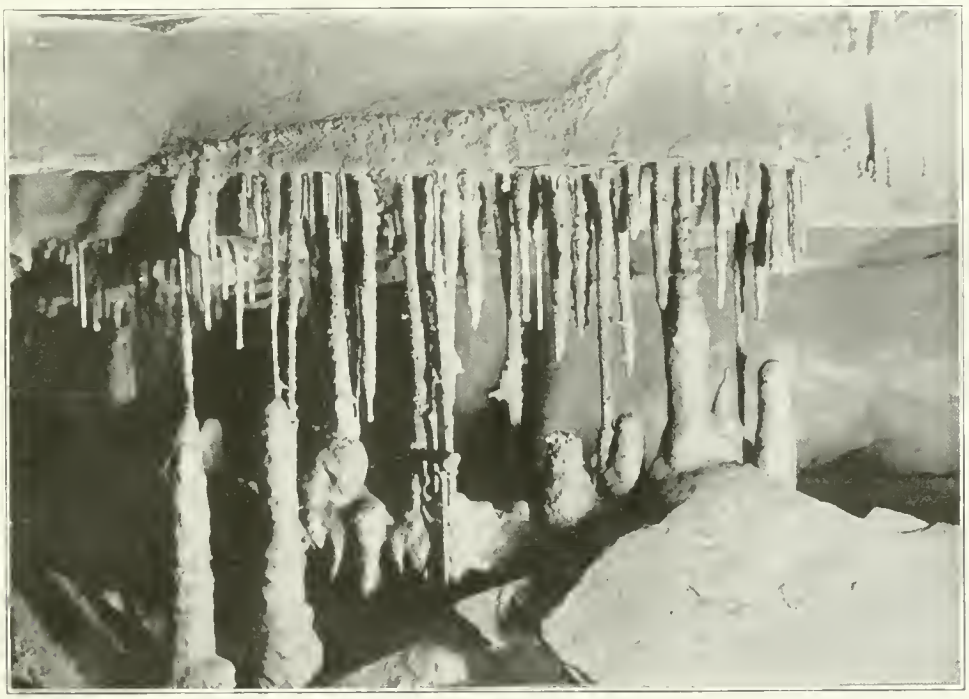
At the time of the organization of Orange County, in which West Baden is located, the section of land containing these medicinal waters was set apart as a government reserve. In 1832, however, it was decided in the general assembly to dispose of these lands at public sale, and the tract was bought by Dr. William A. Bowles. A few years later Dr. John A. Lane, who had previously rented the tract from Dr. Bowles and established a health resort, purchased the seven hundred and seventy acres which embraced what was then known as the mile lick, and established his own health resort, which he named West Baden. During the period of his lease of the springs from Dr. Bowles things had not gone smoothly between landlord and tenant, and when the tract was divided and the two resorts known as French Lick and West Baden established, the rivalry between the two became exceedingly intense and bitter. The last installment of rent, it is said, which was paid by Dr. Lane, was held until a watch had ticked out the exact minutes of the term of expiration, and then the rent money was handed over in silver coins previously blackened in the strong sulphur water of the springs. An attractive frame hotel was immediately erected at West Baden by Dr. Lane, beginning a career of prosperity for the famous watering place which has lasted for more than three-quarters of a century.

Prior to and during Civil War days this section of the state came into national prominence in decidedly contrasting ways. For not far from West Baden a settlement of Quakers maintained one of the best known underground stations for runaway slaves which was in existence throughout the length of that famous "railway," while at French Lick Springs, a mile distant, an attempt was made to introduce slavery into the state in a way that brought ringing protest from all sections of the North. In 1858, W. A. Bowles was indicted for

bringing seven slaves into Indiana and maintaining them there, in violation of the Constitution, in a state of slavery. He pleaded that the slaves were the property of his wife, and were only temporarily at the French Lick Springs, having been brought from Louisville for a short time for their health. The case went against him, however, and he was fined $40.00 in the common pleas court; but he appealed to the supreme court. There were seven separate indictments for the seven negroes, only one, as a precedent, being tried. While the case was pending in the supreme court, Dr. Bowles appeared in court and announced, in answer to charges on the other indictments, that should the supreme court decide adversely to him he would plead guilty to the other six indictments. Proceedings on these indictments were then deferred until the decision of the supreme court was received; the decision being against him, he accordingly pleaded guilty to the indictments and was fined a nominal sum and costs. The case attracted must interest at the time, the hostile attitude of the North and South, the Kansas war, the John Brown insurrection, and the Dred Scott case adding to the interest. Severe comments were made by the New York *Tribune* on the conduct of Dr. Bowles in endeavoring to establish slavery on the soil of Indiana.

Practically all of the section of the country surrounding the famous springs valley is honeycombed with subterranean channels. Caves and weird underground streams and passages abound, in all of which peculiar specimens of blind fish and crayfish have been found. The sinks of Lost River and of Stamper's Creek are always a source of interest, both to the student and to the casual observer. True to its name, Lost River disappears from view, but reappears in a gushing stream near Orangeville. For most of the distance underground, all trace of the stream is lost, but at one spot along the way it has been discovered and can be reached through a cave. Stamper's Creek in a small way is a counterpart of Lost River, except that it lacks the dry bed which can be followed in the case of the larger stream. Stamper's Creek sinks and rises again at Spring Mills. Its source has been traced by the passage of sawdust and other fine material with which it has been tested.

In natural beauty this part of the state is famous both for its caves and for its picturesque ranges of hills, the scenic wonders of both tending to perpetuate the legends and stories which abound. Through one period of its history a band of outlaws held full sway, and many are the stories of pillage and robbery, of hidden loot, of pursuits by angry residents, and of bandits discovered, but never brought to trial. These tales, however, belong only to the past, for now the famous spots ring with the laughter of picnic parties and the hills are responding amazingly to the magic touch of orchardists. Burton Heights, Mt. Erie, famous in other days for the Erie Tower with its winding stairway and dizzy porticos—and also for its chicken dinners—Cross' Cave, Cave of the Winds, and the Gorge, are well worth



"Cupid's Net," Marengo Cave.

The rise of Lost River.

visiting and are easily accessible, while Marengo Cave, famous for its crystal palace, and Wyandot Cave, known as the most beautiful cave in the world, can be reached conveniently by automobile.

CHILDREN'S HEALTH CONSULTATIONS IMPORTANT

The conduct of children's health consultations in the rural sections of the state of New York constituted the most outstanding piece of work undertaken by the state division of child hygiene in 1920, and possibly the one most productive of definite accomplishments. Over 2,700 children in ninety-nine municipalities and six counties were examined, and through the assistance of the division, a number of additional consultations were held by local agencies. About 76 per cent of the children examined had defects, and half of these children needed further medical attention and care, while a third of them needed special nutrition oversight. Children needing medical care are referred to their family physicians. Adequate follow-up work has been instituted in many of the localities and a large number of the children have been satisfactorily treated. The demand for the service has become so great that it is impossible to meet it.—*Health News*, New York Department of Health, February.

STUDENT NURSES TO GO TO Y. W. C. A. CONFERENCE

The Y. W. C. A. is planning to invite student nurses from hospital training schools of the Middle Western section to attend its college student conference at Lake Geneva, Wis., from August 23 to September 2. The Association feels that aside from the benefit to the student nurses themselves, a real interest in nursing as a profession may be aroused among the seven hundred university and college women at the conference.

The following letter from Miss Anna C. Jammé, director of the California State Board of Health, and president of the National League of Nursing Education, gives a favorable account of these conferences in California.

"I have been watching the student conferences with very great interest, and their effect upon our schools. From my observation and reports from superintendents and nurses, it would seem that already it has had a wonderful effect on the life of the students and their outlook on their training and future work.

"The conference last summer at Asilomar was the first in this western territory. I attended this conference and was deeply impressed by the wonderful spirit of the various groups of college students and the ease with which our students were assimilated into these groups. Twenty-five student nurses attended, and several were sent by their hospitals with all expenses paid. One hospital sent two as a reward for having the highest standing in the school.

"In February a mid-year conference was held at Mills College for three days. I attended the dinner on the closing evening, which was most inspiring. Twenty-two of our students were present. Each college had its own table, with its colors, and gave its songs and responded to its toasts. Our students had likewise their table, colors, songs, toasts, etc. It was really very wonderful, and I came back with a new sense of the dignity and poise of our own students.

"This we can readily see is bringing about an interest and enthusiasm in the school life of our students which they have never had before, and the contact with other students and having a share in their activities will go very far in promoting a new spirit in our schools. I hope this work will become established in all of our schools wherever it is possible, and that students from each school may be sent to summer conferences with their expenses paid. These students will not only receive mental stimulus, but also physical recuperation, and will take back to their fellow students a new inspiration upon which to build their ideals during the year."

RECOGNIZES VALUE OF THERAPIES

A. L. Bowen, former superintendent of charities of Illinois, in speaking of the remarkable change in mental patients from the "maniacs" of twenty years ago to the quiet and well behaved patients of today, gives hydrotherapy and occupational therapy their share in the bringing about of this advance. He says: "Hydrotherapy is a humane, soothing treatment for the agitated and disturbed. Occupational therapy, education classes and other means of interesting patients in the world about them and in themselves, the evolution of the old-fashioned institution into a simple community which is now the marked development of the Illinois system, are the influences which are daily making themselves apparent in the changing character, attitude and conduct of those afflicted with nervous and mental diseases."

HINTS FOR THE HOSPITAL LAUNDRY*

By WALTER TRIMBLE, Chicago, Ill.

THERE is a maxim to the effect that it is not what a man knows, but what he does, that counts. If you will go to your laundry superintendent and catechize him about a lot of things which I have advised that he be required to do, he may haughtily inform you that he knew all about these matters long ago. Perhaps he did. But the main thing is this: Is he doing them?

One thing which he did not know years ago was all about zeolite water softeners, and what is known to the laundry trade as "zero" water, or water of no hardness, and the advantages it offers in laundry practice.

Soft Water

When a physician specifies distilled water in a prescription, he means just that, and nothing else, for reasons well known to himself. In a like manner, when I speak of zero water for laundry use, I mean just that. The lime-and-soda water-softening systems of years gone by were a great help, but they were full of uncertainties and did not soften the water to zero.

A properly designed and properly operated zeolite softener will give a continuous flow of zero water, throughout a given number of hours, in a given volume. If it does not give out zero water both at the beginning and at the end of the day, either it is not right, or it is not receiving the very small amount of attention which it requires. There are several different makes of zeolite water softeners on the market, and they may be had in various capacities, all of which may be purchased with an absolute guarantee. The attention required merely consists of opening a valve once or twice a day and thus permitting a reverse stream of salt water to flow through, which "regenerates" the zeolite.

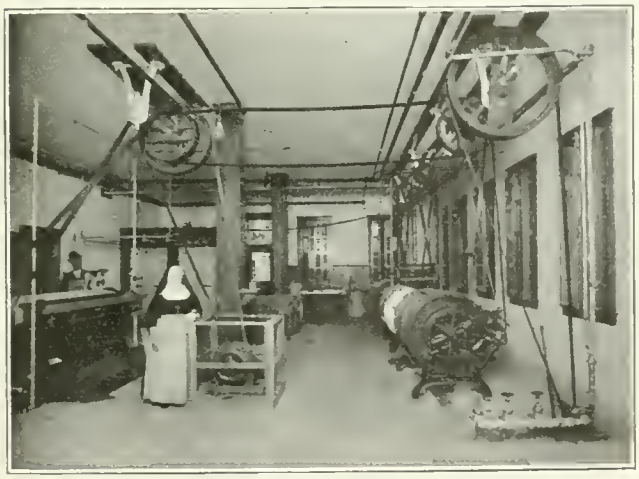
The salesman, in talking to a prospective buyer of a water softener for use in a laundry, usually sets forth as the first consideration the great saving of soap which it will make possible. A zeolite softener does enable one to save a large amount of soap, where the water supply is hard; but to me, especially in the case of the operation of a hospital laundry, the saving of soap seems to be a secondary consideration, important as it is.

First of all, the hospital wants linen that is absolutely free from infectious germs, and this is a matter with which the hardness of the water has nothing to do. Next, and of almost as much importance, the hospital wants linen that is soft to the touch, not harsh and gritty. The bedridden patients are so supersensitive that harsh linen is actually painful to them, and through irritating the skin, such linen makes them nervous and irritable. I know this to be true, for I have had that experience.

Therefore, as zero water is the first requisite to soft, velvety feeling linen, it seems to me that every hospital, large or small, should supply this absolutely soft fluid to its washroom. The same kind of water should be supplied to the boilers, I will add, although the hospital's power plant is not in my domain. Zero water is potable and can be used for all purposes in the institution.

Harsh feeling linen is caused by the use of hard

*This is the eighth of a series of articles by Mr. Trimble, on the hospital laundry, appearing in THE MODERN HOSPITAL.



SMALL WASHROOM IN HOSPITAL LAUNDRY

This illustration gives a good view of the washroom of a small hospital, it being that of the St. Francis Hospital, of Freeport, Illinois. The institution has sixty-five rooms.

SISTERS OPERATING FLAT WORK IRONER

This is another view of a section of the laundry of the St. Francis Hospital, of Freeport, Illinois. Four sisters operate the flat work ironer, which is an ideal crew, for many reasons.

A WELL-ARRANGED HOSPITAL LAUNDRY

General view of the laundry of St. Joseph's Hospital, of Omaha, Nebraska. The washing machines are at the right side, by the windows, and thus receive plenty of light, as also does the flat work ironer, which is by the windows in the rear. The extractors are conveniently located in the center.

water in washing and rinsing. The use of hard water means that the goods washed in it are going to be impregnated with what is called "lime soap," a harsh, gritty substance, which gives the goods the feeling of sandpaper, and which also gives off a rancid odor. This substance is really a combination of lime, magnesia, and grease, and it is insoluble in the regular washing process, although it can be removed by a hot bath of acetic acid, followed by a hot rinse. But it does no good to remove the lime soap, if the goods are again washed in hard water, for in that event it will immediately be formed again in the fabrics.

Soft Water Rinsing

Until recently, opinion has been divided as to the advisability of rinsing with soft water. This was because hard water seemed to remove the soap more quickly and more thoroughly than the soft. Scientific experiments, however, conducted by Dr. H. G. Elledge, in the Mellon Institute of Industrial Research, which is located in Pittsburgh, have settled this dispute, as far as thinking and open-minded men are concerned.

When a load of goods was rinsed in hard water, it was noted that soap curd (which is lime soap) rose to the surface and floated off. But this soap that turned to curd and then floated off, it was found, was only the soap that was held in solution in the water, and it did not include the soap that was in the pores of the fabrics. Instead of floating away in the hard water, it was found, whatever soap was in the goods was "locked in," in the form of insoluble lime soap.

It was noted that when goods that had been rinsed in hard water were extracted (that is, when the water was removed in the centrifugal machine) the rinse water came out perfectly clear, with no trace of soap, and from this it was assumed that the goods in the machine contained no trace of soap. It was further noted that when the fabrics which had been rinsed in soft water were extracted, the waste water had a slightly milky color, indicating the presence of a trace of soap, and from this it was assumed that the former goods were more free from soap than the latter.

But the reverse was the case, as an analysis showed. In the first lot, the insoluble lime soap was "locked in" and did not discolor the water; but in the second case, the little soap that remained in the goods was still in a soluble state, so practically all of it came out when the water was extracted, that being the reason for the milky appearance of the water.

There is another thing that your laundry superintendent did not know "years ago," for it is

Delivery end of the big flat work ironer, in the laundry of St. Joseph's Hospital, of Omaha, Nebraska. A side view of this machine may be seen in one of the other illustrations.

one of several scientific facts in regard to laundering that have lately been proven in a reliable chemical laboratory.

Soap Saving

Of all the prescriptions for saving soap I have heard, the best and easiest one to follow is this: "Don't use so much." In nearly every washroom, a large excess of soap is used. This is on the principle, practiced by most mortals, that "if a little bit is good, a whole lot must be better." Whether it be in using soap or in taking pills, in eating or in drinking, the human tendency seems to be to overdo it.

Zero water makes it possible to save soap, but it does not make it impossible to waste it. Experiments with waters of various hardness show this: If water contains one grain of hardness

per United States gallon, it requires 1.3 pounds of soap to form a suds on a thousand gallons of that water; if it contains two grains of hardness, it will require 2.6 pounds; if it contains three grains of hardness, it will require 3.9 pounds, and so on. That is, every grain of hardness in a water causes the loss of approximately 1.3 pounds of soap. The only way in which this loss can be cut off is to soften the water.

Thus we see that a small amount of hardness, even as little as three grains per gallon, causes a considerable increase in the soap bill. This also applies to washing soda, which is always used in connection with soap, in about the same relative proportion.

Use of Dry Soap

Until recently, the universal practice in the washroom has been to make up a liquid solution of soap, with soda added, and put this into the washing machine. The soap, purchased in the form of chips or flakes, was melted in a tank, by means of steam. This is still the general practice, but one that seems to be better is coming into vogue.

Different firms are now furnishing pulverized soap for use in the laundry's washroom, and this is put directly into the washing machine, thus doing away with the trouble and expense of making a liquid detergent mixture. The soda, also, is put into the machine in its dry state, either separately or mixed with the pulverized soap. This is known as the dry-soap method.

Some claim that a given quantity of pulverized soap has a greater detergent power than the same amount of soap used in solution, but this does not appear to have been proved. I am inclined to think that the economy in using pulverized soap comes from: (1) The washman will use less soap because he sees the soap itself, instead of a liquid solution which does not convey to his mind the idea of quantity. (2) The time consumed in cooking the mixture is saved. (3) It saves a great many steps for the washman, as he does not have to go over to the soap tank scores of times each day, to get a bucketful of solution, but can have the powdered soap near at hand. (4) It saves the steam which is required to cook the soap.

A glimpse of the hand ironing department of the laundry of St. Joseph's Hospital, of Omaha, Nebraska. As will be seen from the accompanying illustrations, this plant has an abundance of light and fresh air, and its equipment is of the very best.

The use of pulverized soap, which sometimes is also referred to as powdered or granulated soap, is spreading. It seems to have merit, and is at least worth investigating. Remember, however, that this is not domestic "soap powder," much of which is adulterated and altogether unfit for use in a laundry.

Buy nothing but the best soap for your laundry department, with a specified analysis and a guarantee as to moisture. The best soap is the most economical, from every standpoint, not only for use in the laundry, but also for all other uses. Do no fail to consider the moisture content, for a soap may be 40 per cent water and show no trace of it. Soap is still rather expensive, so be sure that you do not pay soap prices for *aqua pura*.

CARRY ON CHILD HYGIENE WORK

A report on a year's work in child hygiene carried on by C. P. Knight, of the United States Public Health Service, in cooperation with the state board of health of Missouri, and with all private associations interested in the work, shows results of much general interest.

In sundry cities a house to house canvass was made to determine the percentage of birth registration, the sanitary conditions of the home, the amount of milk used, the relative income, and the relation between prenatal influence and infant mortality. The parents were greatly interested in the work and helped unhesitatingly. Better health supervision of young children and the correction of much improper eating and sleeping habits resulted.

In other cities school hygiene was begun by weighing and measuring the children. The results stirred up a friendly rivalry among the children to see which could first reach the proper average. Many mothers attended talks given to parent-teacher associations, and learned that when a child was underweight (7 to 10 per cent below average) and did not gain as he should (half a pound a month between eight and twelve years of age) it was probably due to some physical defect or to faulty living.

With the mother's consent, underweight children were examined physically; and both child and mother were questioned in each other's presence. Many physical defects and faults, such as late bedtime and improper eating were disclosed. Suggestions as to how the troubles might be rectified were followed up by a public health nurse, who visited the homes and urged the remediable measures. Everywhere both parents and physicians warmly cooperated in the work.

Rural school surveys showed that though the country child has the advantage of fresh air and outdoor life, he usually sleeps with closed windows and subsists, especially in fall and winter, on pork, hot biscuits, gravy, and sorghum. In the summer he has home grown vegetables.

HOSPITALS AND HOMES OF THE SALVATION ARMY

TWO noteworthy additions within the year have brought the hospital and rescue home program of The Salvation Army to an eminence shared by few organizations in the United States. This work has grown so rapidly and with such complete success that the homes and hospitals in many places have attracted the attention of city authorities and generous citizens, whose help has made possible the striking improvements which have been introduced this year.

The Evangeline Booth Home and Maternity Hospital was dedicated in Boston February 24, 1920, by Charles F. Weed of that city. This institution is the high-water mark reached by the women's social department of The Army, and in its appointments and equipment is readily in accord with the highest standards set for the care of unfortunate women. The stone building in which it is situated has been thoroughly remodeled in an effort to render it entirely suitable both as a rescue home and a hospital. In the finishing and arrangements every effort has been made to eliminate, from the home portion of the building in particular, anything which might smack of the charitable institution. Decoration, furnishing, and accommodations, together with the kindly treatment for which the lassies of The Salvation Army are famous, are calculated to give the Booth Hospital all of the "homey" atmosphere possible.

The reception room at the Evangeline Booth Home and Maternity Hospital, Boston.

There are three large staircases which give access to the hospital wards on the floor above. These have been equipped in the most thoroughly modern style, with large and small wards, private and semi-private rooms. The bassinet ward is a place of particular pride to the workers and nurses in charge of the building. With its thirty-five little baskets swinging jauntily from poles, it is in every way an ideal place for a very young man or woman to rest for a few weeks before starting out in the strenuous business of life.

There are also sterilizing rooms, an emergency ward, diet kitchens, a steam table to keep the food warm while being sent up to the patients, and a new device for milk storage. The two operating rooms are furnished with the finest of instruments, appliances, and lighting devices. Large balconies stretch along the southern elevation of the building in a way that affords the best opportunity for open air convalescence.

The dormitories, play rooms, nurseries, and rooms for the older children are all situated on the top floor, while laundry, laboratories, examination rooms and refrigerating plant for food storage are in the basement.

Nothing has been spared and nothing has been neglected in making this institution a real home, and in giving every facility with which to minister to the sick.

The other particularly notable addition to the hospitals and homes of The Salvation Army last year is the $250,000 structure at Greenville, S. C. The sum needed for this home was subscribed half by the cotton mills of the vicinity, and half by The Army. It is interesting to note that the contributions were apportioned among the mills by the committee of factory men in charge, according to the number of spindles in each establishment. Division of the budget by the number of spindles resulted in eleven cents being given by each man for every spindle operated there.

The $250,000 was not sufficient to complete the building as it was planned, for ample allowance has been made in the project for growth of the demands upon the hospital. It did, however, make possible a large and finely equipped building, so designed that additions may be made to it from time to time as the need arises, and funds are available.

This institution, like the Evangeline Booth Hospital, has been equipped with all that is finest and newest, and will insure the safety and comfort of its patients. Medical care of the highest type has been arranged for through the cooperation of the authorities.

The Boston hospital is particularly well supplied in this respect by virtue of an agreement

The x-ray room at "Poor Man's" Hospital, Boston.

The dental clinic at "Poor Man's" Hospital.

made with the Tufts College school of medicine, whose faculty has undertaken to furnish all the medical, surgical, and dental care and advice to the hospital, which will in turn be available to them as a clinic.

Appreciation of the facilities and of the excellent equipment and personnel of the institution by the doctors who are carrying on the work there is shown by the fact that they have arranged for the accommodation of their own private patients there when vacancies among the gratuitous or semi-gratuitous cases exist.

It will be seen that medical assistance of such high caliber is an advantage which, in ordinary circumstances, would be entirely out of reach of any of the women who normally come to the hospital.

Army Operates Twenty-six Hospitals

The hospitals mentioned are but two of the twenty-six Salvation Army institutions operating throughout the country. It is true that they are the newest and best, but the home and hospital at Cleveland, O., is not far behind them. Until the completion of the Boston hospital, the Ohio institution was known as the finest one maintained by The Salvation Army anywhere in the world. More than 8,000 women and children pass through these homes and hospitals in a year. This is a real and vital work, because it touches on one of the saddest and most deplorable conditions in our social system, the fact that so many women must suffer and bear their children in the poverty and dirt of their homes, unable to purchase the comforts and safeguards which would so greatly mitigate their lot. The Salvation Army hospitals exist for the purpose of ministering to such women, and of giving to America better children, born under better conditions, and with more of a chance of attaining full and useful manhood and womanhood.

No charge is made for any of the facilities or care offered by the institutions unless the patients are able to pay, in which case they pay in full or in part, according to their wishes and ability. In one hospital at Covington, Ky., from which figures are available, approximately one-fourth of the patients paid the full rate, half the part rate, while 25 per cent were cared for entirely free.

The percentage of patients paying full and part is normally lower than this in the maternity hospitals, for the Covington building is devoted to general hospital purposes and until lately worked in connection with the city government.

Existing, as the hospitals do, largely for the purpose of caring for the mothers, with little or no remuneration, it has been impossible for this twenty-six link chain to be built up from the general funds of The Salvation Army. The maternity hospitals and rescue homes have often been indebted to generous citizens who have made possible their establishment and growth.

Until recently the New York Women's Home and Hospital occupied only a few apartments in an old dwelling in New York City. Then came a gift from a friend, who would not allow his name to be published, which made possible extension of the establishment until now it occupies all five stories of a fireproof building. This institution has the best and most modern equipment.

A similar story is that of the Detroit hospital. This institution has long done yeoman service, caring for hundreds of patients each year. A heavy debt was saddled upon it, however, and there seemed to be no way in which the superintendent and his workers could free themselves. Then John Dodge of Dodge Brothers, automobile manufacturers, who had been giving $1,200 yearly

to provide milk for the babies, came forward with a gift of $12,000, which cleared the most pressing note. When this philanthropist died a few months later, a bequest in his will gave to The Salvation Army in Detroit the sum of $135,000, of which $40,000 was to be used in paying off the remainder of the mortgage on the hospital and maternity home.

Free dispensaries are maintained in connection with nearly all of the homes, while at the Booth hospital in Boston a drug store is conducted where the poor may secure medicine at cost, or, if poverty is acute, absolutely free.

More than a Hospital Side

But there is more than a hospital side to these institutions. Quite separate from this is the rescue work which is always carried on. Pitiable as is the plight of an unmarried mother, homeless and penniless, it is not worse than that of those other girls and young women who come daily to the rescue homes scattered over America. There are some Salvation Army rescue homes where there is no hospital, but there are no hospitals where there is not a home. To these places come unhappy creatures of every sort, either on their own initiative or encouraged by Salvation Army lassies working in the slums or restricted districts of the cities. Their clothes are bedraggled with the mud of the streets, but their minds are still more besmirched from contact with the underworld. Hundreds of the women come each year to the rescue homes, some seeking shelter of their own free will, others by order of the law. The problem of dealing with these unfortunates is a difficult and many-sided one, a question that must be solved by tact and resource rather than rule and system. They are all different and each responds to a different method. Only matrons and lassies who have had years of experience are able to cope with the changing demands and conditions. Some of the women need to be given work, others respond more easily to rest and seclusion, some have had education, and have come from beautiful homes. It is evident that they would respond best to a different sort of care than those who have known nothing but slums and rookeries.

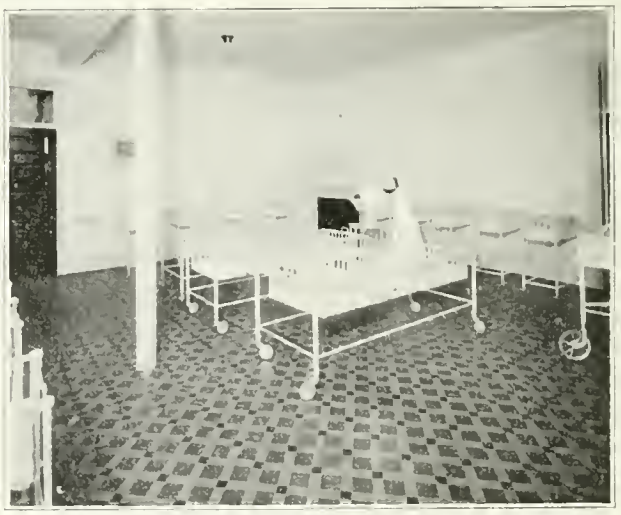
All these things are dealt with, all these problems are solved, and, of the thousands who pass through The Salvation Army homes of the kind each year, 80 per cent of the girls are able to retrieve themselves and start out on better lives, wholly because of the help and influence given them there. This figure does not include the women who have gotten out of touch with The Army. If these could be found, it is doubtless true that even this figure of 80 per cent would be largely increased.

This work is wholly charitable, is entirely the work of love, mercy and of service. It takes in the refuse of humanity, the outcasts, the ostracized, and, by scientific and psychological, as well as human and moral means, sets them once more on their feet, able to resume the righteous lives which they once knew. Of course, when the work is taken as a whole, there are many failures, but there are so many more successes that the value of the enterprise is certainly not open to question.

Connected with the primary work of helping the girls from their sordid lives, is the educational department of the work, which fits them for some worth while occupation which will enable them to maintain themselves by honest and decent means after their discharge from the home.

Nor are these places to be counted as "institutions." They are homes in every sense of the word, they are cheerful and bright, governed by as few rules and regulations as possible, and run with the intent of contributing always to hope and the possibility of regeneration. One of the few rules that is inflexible is that the women shall not engage in mournful accounts of their lives and miseries. This, in its psychological effect, has been proven an invaluable consideration.

The Army also supports numerous other enterprises independent of its hospitals and rescue homes, as such. The slum settlements are, however, allied institutions in their ministrations to the sick and needy of the tenement districts. The lassies go out from them in response to calls for help, or to take food, clothing, coal, medicine—anything. Nurseries are usually maintained in connection with these settlements, where the children of working mothers are cared for during the day. Free dispensaries also form a branch of this work, while medical advice is always cheerfully furnished.



The bassinet room at the Evangeline Booth Home and Maternity Hospital.

Men's industrial homes are also allied in nature. To them come those who for one reason or another are unable to support themselves at their trade or craft. They must be convalescent, crippled, aged, or otherwise incapacitated for regular employment. To many such the thought of becoming inmates of institutions, wards of the state or county is very distasteful, and to these the industrial homes of The Salvation Army offer a solution of their difficulties. They may stay there, working as much as they are able at their trades, or even learning new ones. They are saved the feeling that they are burdens upon the public and that they are objects of charity because of the work which they are doing, but they need only work to the extent of their ability or strength.

Combine with these enterprises the foundling homes where the tots without home or protectors

Part of the well arranged diet kitchen at the Evangeline Booth Home and Maternity Hospital.

are taken in and cared for; the workingmen's hotels and the boarding homes where young women who are strangers in the city may live and enjoy a cheerful home life and entertainment, and one will understand that the work of The Army is by no means confined to hospital and rescue work, or to the evangelical work by which it is best known.

The Army exists to serve, be it by succor of body or soul. It asks only if there is need, and it gives, freely, fully, willingly. Thought of credit for its labors, of recompense or praise never enters into the calculations of the organization, much less into those of the open-hearted, open-handed lassies and officers.

Twin operating rooms at the Evangeline Booth Home and Maternity Hospital.

But none of these varied departments and charities is self-supporting. All must be maintained and increased as the need and field for them enlarge. This all entails a drain upon the Home Service Fund, which, under the present plan, is furnished by an annual appeal to the nation rather than through the former system of sporadic and irregular offerings collected by the various posts and corps.

Army Adopts New Method

So it is that the tambourine of other days has been discarded in favor of the newer method, for it has become evident that the people of America, largely by virtue of a better understanding of The Salvation Army, would rather contribute to a single and business-like fund than small irregular ones.

On May 10 to 20, last year, The Army made its Home Service appeal for $10,000,000. This fund is being used for support of the activities within America, and furthermore, the greater part of the sums subscribed in the various sections of the country will be directly applied to work in those sections, so that the charitable return through The Salvation Army is in exact proportion to the support of the Home Service work by that community. The appeal is for Home Service, and it is wholly and precisely for that.

An old negro sent to a hospital, upon his arrival was placed in a ward, and one of the nurses put a thermometer in his mouth to take his temperature. When the house doctor made his rounds, he said:

"Well, my man, how do you feel?"

"I feels right tol'able, suh."

"Have you had anything to eat yet?"

"Yessuh, I had a little."

"What did you have?"

"A lady done give me a piece of glass to suck, suh."—*Boys' Life.*

The MODERN HOSPITAL

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CHANCE OR EXPERT GUIDANCE

ONE of the perplexing questions which communities and benevolent individuals are not infrequently called upon to answer, is whether or not they will conutribute to the establishment and maintenance of a hospital. In most instances the project has been launched by a group of interested individuals who may have one or more of many motives for promoting a particular type of hospital in a particular locality. In many cases, the community and those individuals and firms whose moral and financial support is sought are not consulted when the plan is being formulated. What is asked of them is support, not opinion concerning the project. The strong appeal of the hospital idea frequently brings the desired response. Not a few communities, monied men, and industries, however, are asking to know something of the supposed need which is calling for a proposed hospital; whether the need can be adequately met by increasing the facilities of some existing hospital or hospitals; whether the proposed location is the best available location; and kindred questions. To these questions there may be no satisfactory answers. The promoters of a hospital project will, as a matter of course, do their best to answer, but the motives which have activated them may not be those which would enlist the support of a community or a philanthropist.

Rarely is there an organization to which one can turn for accurate information and authoritative advice concerning community needs for hospital service. There should be such organizations.

Most American cities have grown up with little planning. Chaos, economic loss, and ugliness frequently result. Hospitals in these cities have shared the bad consequences of this lack of planning. They have not been located in relation to the geographical distribution of population, nor were they planned in relation to the needs of the people for various types of hospital service. There are developing experts in hospital planning, but thus far most of them have given their attention largely to problems of construction, equipment, and organization. There ought to be expert advice available for a community as to its need for hospitals, their types, distribution, and other community relationships. Likewise, let us hope there will develop more community intelligence which will demand such service.

PREVENTING NEEDLESS NOISE

"NEEDLESS Noise!" How often all noise seems to be needless! Elevated trains and street cars, automobile horns and small boys calling "Extry" all seem part of a conspiracy of hammering. When one is well, these may be merely sounds, as one drops farther and farther from the one hundred per cent point of health they become needless noise, irritating noise, and finally, unbearable noise. When one is ill enough to be in a hospital, it is quite likely that sounds made by the lively personnel of that hospital are irritating if not unbearable noise.

A Cleveland hospital formed a "Society for the Prevention of Needless Noise" which did much toward lessening the noise horror. It issued humorous and very much to the point bulletins, and built up a system of rules which were executed by silence policemen. The system included a tapping on the shoulder by the policemen and a gentle reminder to "Remember our guests," the reminder becoming less gentle if unheeded. A daily report was handed in by each "monitor," the report showing the time and place of the occurence of needless noise, the name of the transgressor, and his response to the courteous reminder of the monitor. It worked like a charm. Supplementing the monitor system, each member of the hospital personnel was asked to serve as a committee of one to help convert the few members and frequenters of the institution who had not been up to that time affected.

Perhaps your institution could be reached by

the formation of a society such as this one, even though exhortations in the past may have failed. If everyone could realize how much harm they do by needless noise, if they would close doors, not slam them, lay things on the table, not throw them, what a rubber-tired institution would result! If this blessed campaign could be carried outside of hospitals, who knows but that we would need fewer institutions?

FOREIGN DELEGATIONS STUDY OUR INSTITUTIONS

THAT the organization of our health activities, looked at as a national and international problem, can be measurably promoted by the interchange of knowledge and ideals among various countries, few will deny. Wherever programs of preventive medicine have proved ineffective in the past, their failure has been in no small measure due to the fact that they were too limited in scope or lacked perspective. The factors that enter into any public health program are constantly widening in their ramifications. Out of individual hygienic practice there evolved the ideal of community health. Local health departments very early emphasized the function of the state in promoting the public health; and as disease knows no boundary lines, the international aspects of health questions have rapidly crowded to the foreground. Any agency, therefore, which makes for international collaboration in matters of scientific knowledge along medical and public health lines is performing a service of high value to humanity. Such a service is being rendered by the Rockefeller Foundation in inviting various foreign delegations and commissions to the United States for the purpose of studying our public health organizations and institutions, and our system of medical education, at the same time giving our scientific men and executives the benefit of their ripe experience. Notable among these visitors is Dr. Carlos Chagas, director of the Department of Public Health of Brazil, who discovered the parasitic malady technically known as "Chagas' disease." Dr. Chagas spent two months in the United States familiarizing himself with important phases of medical and public health training and with developments which have a bearing on his administrative work in Brazil, and delivering courses of lectures at Johns Hopkins University and the Harvard Medical School.

Two other distinguished visitors were Sir Wilmot Herringham and Sir Walter Fletcher, both from England, the former chairman of the Committee on Medical Education of the University Grants Committee, and consulting physician to St. Bartholomew's Hospital, the latter secretary of the Medical Research Council. These gentlemen visited this country in April and May to study our system of medical education.

Earlier in the year the Rockefeller Foundation had as its guest in America, Dr. C. C. Choyce, head of the Full Time Surgical Unit, University Medical School and Hospital, London, England, who came to the United States to study the development of surgical teaching in some of the leading medical schools, particularly the status of the full time teaching program in medical schools, and Dr. A. E. Boycott, director of the Department of Pathology, University College Medical School and Hospital, London, England, who came to observe full time teaching positions as well as the development of the teaching of pathology in some of the medical schools.

Delegates and commissions, under the same auspices, have also visited the United States from Brussels and from Czecho-Slovakia, to study medical education and public health organization and institutions in America.

Missions of this kind offer mutual opportunity for inspiration and suggestion and are bound to promote higher ideals of scientific medical practice.

PSYCHIATRIC NURSING

WHEN Florence Nightingale went to Kaiserwerth, Germany, to study in the school for nursing which Pastor Fliedner had established, she found that he was teaching and instructing in the art of nursing the mental sick. Long before he took up this subject, he had studied the prisons and prisoners of Germany and had become the author of reforms in their care and treatment.

From the prisons which were known as such, he stepped into other prisons which were not so frankly acknowledged but which were, if anything, much worse than any penal institution he had visited,—the asylums for the insane. Not having had experience with the sick, training for nursing them had not seriously interested him, but here, in the insane asylums, he saw the need for trained men and women to handle, care for, and treat diseases which he recognized as having many phases and demanding a many sided person to deal with them.

So, having for his first patients nervous and mental cases, he organized a school of nursing, where the first lessons that Florence Nightingale learned were in what we would call today psychiatric nursing. One hundred years have passed, but little more attention is given to psychiatric nursing than was given to it when Miss Night-

ingale entered Pastor Fleidner's little school in Kaiserwerth.

Training for nursing of physical sickness, however, has made tremendous strides and is looked upon as one of the noble professions. In this country, nursing is regulated and licensed by many states, which have set high preliminary educational requirements for admission to the course of instruction, but the course of study and experience in the general hospital school seldom mentions nervous or mental diseases. There are a few states which support training schools in their state hospitals for nervous and mental patients. These schools have few standards which all recognize. There are not more than four or five states in which any effort is made to support psychopathic institutes or psychopathic hospitals and institutes. Several attempts are now being made to establish schools in psychiatric nursing in connection with the state hospital service. These schools all require a high educational requisite to enter and qualify for registration. Some of them are reciprocating with general hospitals, affording the latter's pupils six to nine or even twelve months of study and experience with mental sick. The state hospital school pupil in turn secures in the general hospital those subjects in which the state hospitals furnish no material, such as children's diseases, obstetrics, etc. Occasionally a state hospital service affords sufficient surgical experience.

Feeble efforts are made to establish registered schools in state hospitals to feed into a central psychiatric school which shall be a postgraduate and finishing school. The opportunities for nursing study and experience in the state hospitals are only faintly seen and realized. That they can teach every subject the nurse requires for her registration, except possibly childrens' diseases and obstetrics, is just beginning to dawn upon us. In addition to this, it is a field for experience and study in psychology and psychiatry, both of which must be of inestimable value to any nurse in general practice, in public health or school nursing, or in teaching.

The few schools in psychiatric nursing are deserving of the support and sympathy of the nursing and hospital world.

BEING OURSELVES

HOW many of us waste time, our own and that of other people, pretending to be what we are not? And to what advantage? In the end, and the end comes quickly enough, we lose much more than we have gained. We often lose that which is really precious—sincere respect. Have we lost any of that respect, you and I?

The real value of being oneself must be evident to each member of a hospital family if he learns as he lives, for in the hospital that analysis of body and mind is made, which throws true values into high relief. The brave are seen as the brave, and the querulous, the ill-bred, and the patient ones, as they really are. And where is the pretender seen to a better disadvantage than in the hospital? Are we learning as we go on living, you and I?

The successful ones among hospital folk are successful really because they are happy in their work. And why happy? Isn't it because they eliminate the unnecessary strain of pretending, and thus acquire a freedom—freedom to think and act straight. For those who must constantly pretend, the effort is wearing. Isn't it true that pretenders gradually drop out of sight, and from various pretended causes? Isn't the real honest-to-goodness cause the fact that they are just pretenders? Are we happy in our work, you and I?

Success may not always be given to the strong, but it has a way of seeking out the sincere. So after all, isn't it worth while to be just ourselves, not only because it pays in the short run as well as in the long run, but because it is so very much easier? Shall we, right here and now, agree to do that, you and I?

JAMES G. JARRETT JOINS MODERN HOSPITAL ORGANIZATION

READERS of THE MODERN HOSPITAL will be interested to learn that Mr. James G. Jarrett has become affiliated with The Modern Hospital Publishing Company, and will serve as its vice-president and treasurer.

Mr. Jarrett was for a number of years associated with P. F. Collier and Sons, Inc., publishers of *Collier's Weekly*. He was identified with that magazine during its crusade against patent medicines. Shortly thereafter he became the company's advertising manager, later its treasurer, and finally a director—positions he held at the time of his retirement.

Mr. Jarrett's association with The Modern Hospital Publishing Company, therefore, carries with it not only a considerable increase in the financial resources of the company (its paid-up capital now being $150,000), but also a wealth of experience in the publishing business, all of which will be drawn on in improving the service rendered the hospital field by this magazine.

"To be sure, it is harder for some people than for others to grasp the principles of dovetailing in human relationship, but there is no reason for anyone to give up with the feeling that such principles cannot be acquired."—Aileen Cleveland Higgins.

TRAINED ATTENDANT MOVEMENT MAKES HEADWAY

WE ARE often reminded that the non-graduate nurse or "trained attendant," as she is most commonly called at the present time, is not a new development or discovery of today. There has for many years been a serious gap between the highly trained nurse and her specialized type of medical work in hospitals, with a limited amount of work done outside of hospitals among the fortunate few who could afford to pay for her services, and the public health nurse, as she has been known of late, and her work among the poor. Necessity being the mother of invention, the office of trained attendant was invented long ago. A typical case of her evolution, and the recognition of the need for her type of worker is given by a town of moderate size, in which there are hospital facilities and visiting nurse facilities, developed to a sufficient extent, but in which a study of the sickness reveals the fact that there is a large amount of work which is still undone. It is a type of work which could best be done by a practical nurse, able to do housework, under the supervision of a graduate nurse. There are, of course, problems in the work which should be handled by a graduate nurse.

The members of the nursing profession, if they are to fulfill their greatest duty to the public, must realize that there is a field of activity which they have in the past, and must in the future, fail to cover, and which therefore should be taken over by this other type of women. This is especially true today, when nurses tend to specialize more than they have ever done before. The field of public health work has opened many opportunities for specialization, and taken many workers away from the private duty field.

There must be cooperation between the nurse and the trained attendant, just as between physicians and nurses. They must realize that neither one can get along without the other, and that only by working together can they hope adequately to care for the community.

Scope of Trained Attendant

The scope of the trained attendant has been defined in an editorial appearing last spring in the *American Journal of Nursing:*

"It is not the intention of the nursing body, in giving recognition to the trained attendant, to provide a poorly trained nurse for the poor or middle class.

"It is the intention of the nursing body to have attendants trained, licensed, and so controlled by legislation that it will be impossible for them to practice as nurses, just as it is unlawful for a nurse to practice as a physician. They should be capable of caring for a patient convalescing from an acute illness (when the services of a highly trained nurse are no longer necessary, or where, for a period of weeks, or during convalescence, there must be at hand an intelligent person to give supervision and care until strength is entirely restored); of caring for certain kinds of long chronic cases; of caring for children under certain conditions, and of filling many positions in the home often occupied by highly skilled women needed elsewhere, such as supervising homes in the absence of the mother, looking after well children, traveling with an invalid, or as a companion to a well person."

The nursing body does not intend, in giving recognition to the trained attendant, to provide a poorly trained nurse for the poor of middle class.

It is the intention of the nursing body to have attendants trained, licensed, and so controlled by legislation that it will be impossible for them to practice as nurses, just as it is unlawful for a nurse to practice as a physician. They should be capable of caring for a patient convalescing from an acute illness when the services of a highly trained nurse are no longer necessary, or where for a period of weeks, or during convalescence, there must be at hand an intelligent person to give supervision and care until strength is entirely restored; of caring for certain kinds of long chronic cases; of caring for children under certain conditions, and of filling many positions in the home often occupied by highly skilled women whose services are needed elsewhere."

There are other questions in connection with the trained attendant, and what has been done toward her training and standardization, which Mr. Richard M. Bradley, of the Thomas Thompson Trust, Boston, who has been one of the pioneers of this movement, has answered for us.

1. How do the courses in the training schools that have already been established compare with each other? "There have been in these endeavors two tendencies; one, to put a greater emphasis on the hospital part of the training, and another, to put a large emphasis on the household side of the training. My own experience, and that of others, causes us to believe that the important thing is to give the first emphasis to the home work, creating ability to handle the various family problems and grounding the pupil on the idea that carrying on the household is a basic part of the problem. After this has been done, the technical part of her training, where the hospital comes in, follows to complete her training and ensure her greater efficiency.

"This process may not interest the people who have no interest except in the unsocialized hospitals, but a knowledge of the defects of the training of too many graduate nurses, and the unfortunate tendency among so many women to get away from domestic lines of work, will prove how important it is to look out for this training."

2. Are the schools fairly uniform in their object and methods, if not what are the variations? "Apart from this difference in tendency, I should say that the courses were comparatively alike in their purposes and methods."

3. What is the character of the enrollment? "The character of the enrollment is very varied, just as is the character of the work. There are some gray haired women and some very young; some are fairly well educated, though too old to become student nurses in regular hospital work, who are able to take up specialized work, others who are capable of only doing the work requiring very little mind, and lots of elbow grease, and there are some all the way between."

Prospects of Trained Attendants

4. What are the prospects of the graduates? "The only difficulty with the product of this training is that the demand for their services is so great that they are likely to be pulled off into specialized work where they will become lost to general service. They have abundant prospects and plenty of work, and their field is unlimited. Those adapted for the purpose are constantly being passed on to higher courses, so as to become graduate nurses."

5. What has been the effect of legislation? "The main difficulty of legislation has been that it has been brought forward by the bodies whose main idea is to protect the graduate nurse, and by others who want certificates of nurses and attendants of various grades controlled by legislation. In my judgment, both of these are running off on the wrong lines. Certificates issued by the mayor of a city after six or eight weeks' training are just as impressive to the ordinary consumer as those issued after a three or four years' course by the best training school in the country.

"The way to protect the graduate nurse and the public, in my judgment, is by controlling the placing through responsible offices run in the interest of the public, preferably by private or rather non-political public health associations, which will afford supervision through trained public health nurses to those less highly trained women. For this purpose there is need of educating the public health nurse so that she may be fitted to make full use of all the forces that exist in her community which can be used for the care of the sick.

"What has been accomplished in consequence of attempts at legislation through certificates and restrictions has, in my judgment, been to delay any real progress in protecting the people and satisfying their needs. The best protection for the highly trained nurse is to be instrumental in getting the people proper service."

Laws Regulating Trained Attendants

Several states have passed laws attempting to regulate the training and practicing of trained attendants.

In New York, an amendment to the public health law in relation to the practice of nursing went into effect on May 12, 1920. It defined the qualifications for trained attendants as "Any person being over the age of nineteen years, and of good moral character, holding a certificate from a school for trained attendants connected with any institution giving a course of at least nine months, including six months' practical experience, and registered by the regents of the University of New York as maintaining in this and other respects proper standards, all of which shall be determined by the said regents, and who, after a practical examination, shall have received from said regents a certificate of his or her qualifications to care for the sick as a trained attendant, shall be styled and known as a trained attendant. . . ."

The trained attendant must register his or her certificate in the county clerk's office, and each year it must be again recorded. The examination for trained attendant was waived in the case of anyone who had been graduated or was in training before April 24, 1920. An advisory council was provided for in the bill, to be appointed by the regents of the state university, to advise the regents as to the courses to be pursued and standards to be maintained by schools for trained attendants.

The following rules were drawn up by the committee:

Preliminary Statement: In planning the curriculum for schools for trained attendants, committees having the matter in charge are urged to have clearly in mind the place which the trained attendant is expected to fill. The demand is for a person who is prepared to be of very practical assistance in homes where there is need of personal attendance in cases of minor or chronic illness or during a period of convalescence, after the time of critical illness has passed.

The attendant may be called on to take part in household duties, such as the preparation of meals and the caring for children.

Her training is not intended to prepare her to care for cases of acute illness, although in such cases she may be called on to render assistance to the registered nurse.

It should be understood that the course is intended to train an attendant who will be as valuable in her special field as the registered nurse is in hers. The course is not intended to produce a partially trained nurse.

Rules Relating to the Licensing of Attendants: Incorporation: The school for attendants or the institution of which it is a department, must be located in the State of New York, must be incorporated, and upon receipt of its formal application for registration claiming that it possesses the minimum requirements, it will be inspected by a representative of the Education Department.

Facilities for Practical Experience: For registration, a school for attendants must be connected with a hospital, sanatorium or other institution able to provide a bedside experience in the care of men, women, and children.

Services which are considered as peculiarly adapted for this experience are found in hospitals for convalescent and chronic patients, sanatoriums for tuberculous and nervous patients, infirmaries in orphans' homes, convalescent children's wards, and day nurseries.

A general hospital which conduets a registered school for nurses may conduct a registered school for attendants only when situated in the State of New York, and when it is able to provide adequate clinical material for its student nurses in all required services, and has a daily average of not less than 200 patients, excluding dispensary cases.

Schools for attendants will be approved in other institutions upon satisfactory evidence that the number of patients and the general character of the services do not warrant the maintenance of a nurses's training school, but do warrant the maintenance of a school for trained attendants, and that registered nurses are employed in sufficient numbers to insure the proper nursing of all acute cases and proper supervision of the pupil attendants in training.

Administration: There must be a competent principal of the school who is a licensed registered nurse.

Registered nurses must be in charge of all wards in which attendants are on duty. The number of registered nurses required will depend upon the number of beds in the institution, the type of patient and the facilities for caring for such patients. Under the favorable conditions there should not be less than two registered nurses for every ten attendants in training, to the end that there may be constant oversight of the attendants in order that the patients may have proper care.

Living Conditions: The institution shall provide suitably equipped living quarters for those in training.

Training and Instruction: The instruction must meet the statutory requirements as to preliminary education and length of course.

Schools for attendants to be registered by the Department must provide service that will insure experience in the care of both adults and children, in the performance of household duties and in the preparation and service of food.

The following types of cases will afford such experience. Pupils in training should assist in the case of only such cases: chronic and convalescent medical patients; minor operative and convalescent surgical patients; obstetrical patients. postpartum after third day; normal infants after third day; tuberculous patients; convalescent and well children.

Attendants may not be placed on special duty.

Hospital maintaining both a nurse training school and a school for training attendants:

A general hospital desiring approval for conducting both a registered nurse training school and a school for training attendants must furnish evidence of ability:

(a) To provide adequate clinical material for the student nurses in all required services.

(b) Have a daily average of 200 patients, exclusive of dispensary cases.

(c) An assistant to the principal of the training school for nurses, such assistant being a registered nurse competent to and charged with supervising and carrying on the course of instruction for attendants.

(d) Separate living quarters for the attendants in training.

(e) A number of registered nurses sufficient to direct and supervise the attendants in training, to the end that attendants in training may not be left under the supervision of a pupil nurse in training, and thus interfere with the right care of the patients in the ward.

(f) The uniform distinguishing attendants in training

from all nurses in training, to the end that there may be no confusion of the services to be performed by the different classes of pupils.

Registered Nurse Training Schools in Other States:

Registered nurse training schools without the state, and maintaining schools for training attendants, must in order to retain their registration, conform to all the requirements prescribed for similar schools within the state.

The Massachusetts Law

In Massachusetts, a bill came before the legislature in 1920, providing that "All people who are to take care of the sick for pay, and who are not registered nurses, must have a license to practice as attendants, and shall renew their licenses annually." The waiver states that "Any person in this commonwealth who is engaged in caring for the sick for hire, and who is not already registered under the provisions of chapter 149 of the acts of the year 1910, or who is not entitled to registration under the provisions of section one of this act, or under the preceding provisions of this section, shall be required to file with the board, upon blanks to be furnished by the board, satisfactory proof that he or she is of good moral character, and upon payment of a fee of fifty cents a certificate shall be issued to the applicant, signed by the secretary, which shall provide that the holder thereof is authorized to practice under the title 'Licensed Attendant.' In case of emergency the board may at its discretion waive temporarily the requirement of registration or issuing of licenses for those who are needed to care for the sick for hire." This apparently provides that there shall be no examination, no definite standards, and that all unregistered nurses shall be legally "attendants." The waiver in case of emergency gives still more leniency.

The Illinois Law

In Illinois, two opposing bills were introduced into the legislature, one sponsored by the Illinois Nurses' Association, and the Department of Registration and Education, the other by certain members of the medical profession, and the Illinois Hospital Association. The "Nurses' Bill," as it was called, provided for two classes of nurses, the registered nurse and the junior registered nurse, both to be trained in recognized training schools and licensed by the Department of Registration and Education. The educational requirement was one year of high school work, and the course for the junior registered nurse was eighteen months. The "Doctors' Bill" provided for a one year course to be given to grammar school graduates, and made no provision for the licensing or registering of the graduates completing this course, or the others who might practice nursing.

On account of the opposition to the two bills, a compromise bill was drawn up, providing for registered nurses and registered attendants. The attendants must have a grammar school education or its equivalent, a year's course in a recognized nurses' training school, and registration upon examination by the State Department of Registration and Education. They must register annually. The bill seems to combine the good features of both of the first bills proposed, protecting the standards of the registered nurse, and endeavoring to supply a more adequate number of sick room attendants.

The Department of Public Welfare has submitted to the State Civil Service Commission a new classification of the attendant, the nurse, etc., in the institutions under its control: The first group is that of attendants, about 2,000 in number, receiving from $35 to $45 a month, with full maintenance. Under direction and supervision, attendants care for patients and the upkeep of the wards. A course of instruction is given at each institution, and the attendants must take at least the first year's work. The second group is that of charge attendant, which is promotional from the grade of attendant. This class must have had six months' experience as attendants, and receives $50 to $60 a month, with full maintenance.

The California Law

In California, the legislature passed an act governing the licensing of trained attendants, in 1919. The necessary qualifications for certificates were: eighteen years of age, good moral character, and one year from the passage of the act the applicant shall have had not less than one year's practical experience in the care of the sick in a reputable hospital or sanatorium, connected with a school for trained attendants, and shall have had systematic instruction in certain specified subjects. One year after the passage of the act, an examination will be necessary, which shall be practical in character, and designed to ascertain the applicant's fitness to practice her calling.

Experiments in the actual training and employment of trained attendants have been carried on in various states. There has been little, if any, cooperation between the hospitals trying the experiments, but as Mr. Bradley pointed out, the development has been along practically the same line in all cases.

In New York, the State Board of Nurse Examiners informs us that although there have been for several years courses for trained attendants in the state, they have not been known officially to that department, as in the past there was no provision by law to control such schools, or license their graduates. These schools are the ones conducted by the Department of Public Welfare of New York City, and a course conducted by the Montefiore Home, also in New York City.

Ten or twelve institutions are considering the establishment of these courses at the present time, and several have been inspected and advised regarding the courses, and their formal applications are now pending the action of the regents.

Under a waiver of the nurse practice act, the regents may waive the examination of any persons possessing the necessary qualifications and who have had two years' experience in caring for the sick prior to 1920. Four to five hundred persons have applied, and up to the present time about 125 have been recommended for licenses. From the reports of the various examiners, those applying for licenses have been a very good group, quite capable of giving good bedside care to patients not acutely ill.

According to the secretary of the State Board of Nurse Examiners, there is great encouragement felt over the interest displayed at these examinations, and the Board will endeavor to turn those applying for entrance to nurses' schools who have not the necessary educational requirement, into the schools for trained attendants.

New York City Trains Attendants

Miss Agnes Ward, superintendent of the Department of Public Welfare, New York City, made the following statement concerning the schools for trained attendants conducted by that department:

"The schools for attendants are all connected with institutions in which there is no school of nursing. With one exception, all the institutions care for a special class of patients, as follows: Sea View Hospital, tuberculosis patients; Neurological Hospital, neurological cases; Children's Hospital, feebleminded and epileptic children.

"The Greenpoint Hospital does have an acute general

service, and it did seem advisable to establish a school for attendants there.

"Two of these schools were established on January 1, 1919, one on January 1, 1920, and the fourth on July 1, 1920. The course of study is practically the same in each school, differing only in minor details because of the special class of patients cared for. With these institutions caring for such a widely different class of patients, it has been possible for us to direct the applicants to the school for which we felt they were best fitted. For instance, in the acute hospital there is a more attractive service, and many of the better type of women have been trained there. In the school connected with the institution for the care of mental defectives we have some difficulty in getting the better class of young women interested. Perhaps I should say right here that, in this institution, the attendants in training care only for the sick children and do not look after the children needing only custodial care.

"When establishing these schools we have borne the thought of custodial care in mind; for instance, we did not establish a school in the homes for the aged because there did not seem to be sufficient experience to justify establishing a school in such institutions.

Applicants Fairly Well Educated

"We have been astonished that so many of the applicants have been women with a fairly good education. We do, of course, have a large number who would find it difficult to produce evidence of the completion of a course in a foreign school equal to what is demanded of the nursing school applicants. A number of women who have been in these schools are ambitious to enter schools of nursing and are going to evening schools in order to make up the number of counts required to enter a school of nursing.

"With the exception of the general hospital, the pupil attendants (under the direction of a graduate nurse) are doing most of the nursing; in any complex procedure the work is done by the graduate nurse.

"It is, perhaps, a little early to be very definite about the prospect of the graduates. However, in our department, we employ them after graduation at sixty dollars per month, will full maintenance. I understand that for private duty work the rate is considered about four dollars per day. There has been so much demand for nursing service that so far, the problem of employment has not had much consideration. It seems to us that, in the time to come, there will be ample opportunity for service for the graduate attendant. We have had some little difficulty with women who would enter the school for a short time to get a certain amount of experience and then leave because of the opportunities for earning a good salary outside.

"In the nurses' bill which was passed last year provision was made for the licensing of attendants, the requirements being the completion of the grammar course, or its equivalent. Under this law the school for attendants must meet the regents' requirements.

"As the putting into operation of the requirements of this bill for nurses involved a tremendous amount of work, the schools for attendants have not yet been registered. However, we are just now making preparations to have this taken care of so that the graduates of these schools will be entitled to register.

"In giving a nine months' course it is understood that the attendant can be trained in only the simplest nursing procedure. She does not have instruction in materia medica, but is taught the necessity for care in the giving of drugs and medicines; she is also taught how to measure simple drugs, how to prepare a hypodermic and how to sterilize water so that, if the doctor wanted to leave careful instructions with a trained attendant about the giving of medicine, she would understand these fundamental things about the administration. However, it is generally understood that she has no knowledge of drugs.

"We also have three months extension work. This extension work may be taken, either in the institution where the attendant trained, or in one of the other institutions maintaining a school for attendants. We advise that young women who are planning to take a nursing course should not spend their time taking this extension work. However, for women who plan to continue their work as trained attendants we do advise them to get the additional experience which this three months gives.

"During this three months we do give them instruction about a few of the simplest drugs. It seemed to us better to have a nine months' course, with this extension work, so that the women who felt they could not give a whole year would be able to complete nine months and then go out and earn a fairly comfortable livelihood. The three months extension work ought to give to the women who take it a wider field of service. We have found that an unusually large proportion of the women have interest enough to take this additional three months' course."

The course of instruction is as follows:

Outline of Course:

Elementary Nursing	25 hours
Cooking and Dietetics	20 hours
Hygiene	10 hours
Care of Children and Infants	5 hours
Care of Chronic and Convalescent	5 hours
Accidents and Emergencies	5 hours
Total	70 hours

The extension work takes up the administration of drugs, practical nursing of a more advanced type than that of the regular course, ethics and etiquette in some detail.

In California there are about one hundred practical nurses licensed under the act concerning trained attendants, passed in 1919. The Bureau of Registration of Nurses has approved one school for trained attendants which has graduated fourteen students, the Bureau holding examinations for six of these. The school is in connection with a Sisters' hospital and home for the aged. The hospital affords some experience in acute diseases and also some maternity experience. On being graduated from one year's course the pupils are said to have posed as graduate nurses, taken responsible positions, etc., with the result that the project of trained attendants in this hospital is to be abandoned.

California's Course of Study

The California State Board of Health has prepared a rather comprehensive course of study, and requirements for trained attendant's schools. The requirements are, in brief: a school for trained attendants may be established in connection with a hospital or sanatorium which has not a school for registered nurses; the teaching period must be twelve months in length; there must be a superintendent who is a registered nurse, also a dietitian; suitable living conditions and class room must be provided; and a complete record of each student must be kept on file and open to inspection at any time.

The requirements for admittance to the school are: eighteen years of age, knowledge of reading and writing in the English language, and of simple arithmetic, good physical condition, and good moral character.

The work of educating trained attendants was undertaken by the Thomas Thompson Trust a few years ago, and a school was started in Lynn, Mass., for this purpose. It has since been transferred to Brattleboro, Vt. The course was at first six months, but now a year is required. During the first two months the pupils are instructed by the superintendent of the school and during the second two months they receive hospital training at the Norwood Hospital, Norwood, Mass. The remaining eight months of the course are spent in actual nursing in the homes of patients, under the supervision of graduate nurses of the school. During the first six months, an allowance is paid of $10.00 a month, besides living expenses, and during the last six months, a salary of $15.00 a week. The course of study is very much like those of other schools which have been mentioned. Sixteen students were admitted to the school in 1920, three of whom are to remain on the staff. The graduate attendants, remaining on the staff, receive a salary of $18.00 a week. The Association has a record of great service and usefulness behind it, and the number of calls, which is constantly increasing, proves that the service is needed and appreciated.

An interesting experiment in the training and employment of trained attendants is that of the Household Nursing Association, in Boston. The following sketch of their methods and aims was given by the superintendent:

"The Household Nursing Association was incorporated in 1912 by a group of women who saw the need of providing nursing care in cases where the services of a graduate nurse were not required or could not be afforded. Women of more or less training were sent out by the registry of the Association under the supervision of graduate nurses who visited each case once a week or oftener, to give any necessary advice or instructions.

"The registry always endeavored to send to a case the woman best suited to undertake the work, but it was often difficult to find out the extent of her training or experience. It was therefore decided to give a definite course of training, and the school was opened in April, 1918. The course was carefully planned to give the pupils only what seemed absolutely necessary to fit them for the special work they have to do, omitting all non-essentials.

"During the three years, 139 women have entered the school. Of these, thirty-two were unable, for various reasons, to complete the course, seventy have graduated, and there are at present thirty-seven in the school.

"The tuition fee is $50.00. The course of instruction covers seven months: a six weeks' preliminary course of household training at the headquarters of the Association, six months hospital training, the last six weeks being in post-natal work.

"During the household training the pupils are in charge of a resident instructor, who is a graduate of Simmons College. The cookery includes two branches; that for the invalid and for the family. This covers thirty lessons of two hour periods. The pupils are taught the planning of the family budget, and are taken to market and taught the buying of food.

"They have six lessons in nursing, similar to the Red Cross home nursing course, taught by a graduate nurse, who also instructs them in the elements of ethics and etiquette.

"Their course in elementary physiology, with special emphasis on the digestive tract, together with a brief course in dietetics, gives them a foundation for their hospital work. These lessons are made as simple as possible.

"By having this course precede the hospital training, the pupils, most of whom have had a meager education, cover more ground in the limited period than would be possible if the study were combined with the accustomed hospital routine. Our aim is so to prepare the pupils for the hospital that they enter with some knowledge of the essential requirements and begin at once to take active part in the work of the wards.

"On completion of the household training the pupils are sent to the affiliated hospitals. Reports of their progress are sent to the Association, and the superintendent visits the hospitals to keep in touch with the attendants. Our affiliated hospitals are the Henry Heywood Memorial Hospital at Gardner, Mass., and the Deaconess Hospital, at Concord, Mass. As there are no pupil nurses in either of these hospitals, the pupils do all the work of the wards, except the charting and giving of medicines, which is the responsibility of the graduate nurse in charge of each ward.

"The graduate nurse employed by the hospital has charge of the pupil attendants. She gives them demonstrations in practical nursing, simple classes in diseases and medicines, and supervises all their work in the wards.

"After the seven months' course of instruction is finished, the pupils are sent on private duty under the supervision of a graduate nurse. Their cases are selected to give them as much variety as possible. Each case is visited by the supervisor at least once a week, and oftener when necessary. She inspects the work of the attendant, gives any necessary instruction, and endeavors to adjust any difficulties. Often the supervisor must teach the attendant how to handle the domestic situation in the individual home. It is here that the attendant would fail if she had received only institutional training. With the household training she only needs guidance in applying what she has learned to meet the needs of the home upset by illness.

Diploma at End of Thirteen Months

"The diploma, which is signed by the affiliated hospitals, is not given until the satisfactory completion of the entire thirteen months, although earning begins as soon as the hospital training is finished. The wage for the

COURSE OF STUDY FOR TRAINED ATTENDANTS PREPARED BY CALIFORNIA STATE BOARD OF HEALTH

1. Class Work

Practical nursing procedures	40 hours
Elementary anatomy and physiology	10 hours
Hygiene	14 hours
Cooking and diet for the sick	20 hours
Infant feeding	5 hours
Care of the convalescent and chronic sick	5 hours
Care of infants and children	10 hours
Care of the tuberculous	4 hours
Care of the aged	2 hours
The social aspect of sickness	3 hours
	113 hours

2. Practical Work

Probation, one month: hospital housekeeping, bedmaking, dusting, etc., care of utility rooms, linen, serving meals, etc.

Care of patients, four months: administration of medicines, temperatures, etc., care of convalescent patients, supervision of the chronic sick and aged.

Diet kitchen, two months: preparation and serving of food and preparation of special diets.

Care of mothers and babies, three months: routine daily care, and night duty for one month.

first three months is $17.00 per week; an additional fee of $1.00 being paid to the Association by the family for the expense of the supervisor. The next three months the attendant receives $19.00 per week. After graduation the attendant receives $22.00 per week, with an additional allowance of $2.00 per week for laundry.

"After graduating, the attendants are informed that supervision is released, but that the Association will endeavor to visit each case on the registry at least once, to see that everything is going well both for the family and for the attendant. This has worked out successfully. A large number of the attendants seem satisfied to remain on the registry after graduation, and we keep in touch with all of our cases.

"Experience has shown us that it is unwise to train attendants in the same hospital with pupil nurses. There is inevitable jealousy and friction between the two classes of pupils, and the drudgery of the wards falls entirely upon the attendant, without the interesting nursing care to make this drudgery bearable.

"Our experience also shows us the advantage of organizing the training of attendants independently of the hospitals. If the attendant receives the household training under home conditions, and is sent from the school to the hospital for the necessary experience in bedside nursing, returning to the school for her graduation, she is more likely to feel a loyalty to the Association and not claim to be a graduate of the Hospital Training School.

"The future of the attendants and their proper employment is largely in the hands of physicians. It is not enough to give these women careful training for their special work in the nursing field if they are afterwards allowed to undertake work beyond their ability and without supervision."

NEW ARMY AEROPLANE AMBULANCE

Photographed by Underwood and Underwood.

The first army "air hospital" of the U. S. Medical Corps has been tested and not found wanting. It has a 400 horsepower engine, carries 300 gallons of gasoline, fifty gallons of oil, and it has room inside the fuselage for a patient, nurse, surgeon, and pilot. A surgical operation could be performed there if necessary. When the door, which is open in the picture, is closed, the interior is practically free from vibration and noise.

It is reported that there are less than 300 doctors in all Serbia. In Poland beside the army medical forces, less than 2,000 physicians are to be found to care for the 25,000,000 inhabitants. Additional schools for training doctors are very much needed in these countries, particularly those of the south and east.

PUBLIC HEALTH SERVICE INSTITUTE

The success of the institute on venereal disease control and social hygiene, recently conducted by the Public Health Service, suggests that public health officers, practicing physicians, nurses, social workers, and clinicians are eager for more training and that they will come long distances to get that training (six hundred and fifty persons attended the venereal disease institute), when the best kind of instruction is offered to them.

The Service, therefore, proposes to conduct a general public health institute to take place during the fall of 1921; and to offer twenty-five to thirty courses including the following: Diagnosis and treatment of tuberculosis, nutrition in health and disease, sanitary engineering, clinic nursing and social work, clinic management, courses in syphilis and gonorrhea, mental hygiene, industrial hygiene, child hygiene, vital statistics, laboratory diagnosis, health centers, and various courses in psychology and sociology.

The institute faculty will be composed of seventy-five to one hundred leading authorities, including: William H. Welch, William H. Park, John A. Fordyce, Valeria H. Parker, John H. Stokes, Michael M. Davis, Jr., William A. White, Anna Garlin Spencer, Irving Fisher, C. V. Chapin, and M. H. Rosenau. Other names will be announced later.

If you are interested, the Service would be glad to receive any suggestions you may have.

SAVING BABIES IN EUROPE

A marked tendency to aid child welfare work by state funds is shown in a report on "Infant Welfare Work in Europe," issued recently by the United States Department of Labor through its Children's Bureau. This report gives an account of work in Great Britain, Austria, Belgium, France, Germany, and Italy.

In all these countries legislation designed to reduce infant mortality has been in force for a number of years, forbidding the industrial employment of mothers before and after childbirth. All important European countries have also made provision for maternity insurance. But experience shows that this is not sufficient, and more direct and special measures to save the lives of babies have received government encouragement and aid chiefly during the past decade. Appropriations are being made for the support and extension of baby health centers and home visiting, notably in Great Britain, France, Belgium, and Germany.

Since 1914, England has been making grants of 50 per cent of approved expenditure on infant-welfare work done by either voluntary agencies or municipal or county authorities. The scope of these grants has been enlarged year by year until practically every aspect of infant and maternity welfare is now covered. In France, subsidies up to 20 per cent of approved outlay are given to infant welfare organizations by the government. In 1919, Belgium passed a bill providing for government appropriations to cover half the cost of health center, and other infant welfare activities. In 1918-19 Great Britain spent £258,500 of government funds on infant welfare, and in 1918 France appropriated 650,000 francs for infant welfare work, in addition to three million francs for nursing premiums and maternity benefits. State aid has resulted, according to the report, in a rapid expansion of work in behalf of mothers and babies. It has succeeded in bringing about, also, coordination of all agencies in this field, and in exacting higher standards of work.

THE NECESSITY FOR CORRELATED EFFORT IN HOSPITAL ADMINISTRATION*

By A. C. BACHMEYER, M.D., Superintendent, Cincinnati General Hospital, Cincinnati, O.

THE last decades of the past century were a period of profound change politically, socially, economically and industrially, as well as scientifically. The spirit of positive knowledge was applied in every direction and whenever possible experimental methods were applied and research organized. System replaced chance in the greater part of human endeavor, in manufacturing, warfare, commerce and no less in medicine. The advance has been steady and ruthless and has carried us along with it. The world has learned that science pays. A multitude of professorships have been created, societies have multiplied, numerous scientific journals established, institutes of research endowed, the number of working scientists enormously increased and a livelihood provided for a veritable army of workers. The forward march of science has become inevitable. This vast multitude of workers, daily adds to the sum total of our positive knowledge. This extension of science has resulted in its incorporation with the state, so that today we have departments of agriculture and commerce with many specialized bureaus, and we badly need a department of public health. The part played in the government by highly technical commissions and experts acquires increasing importance each year.

The developments of the last half century have produced more and higher specialization than ever before. Throughout a large part of the century it was thought that one man could cover the range of the entire field of medicine. One year of college study was deemed sufficient time to devote to the study of the healing art. But as the research workers, day by day, amassed the tremendous store of knowledge and as medicine became less an Art and more a Science, it was realized that the day when a single human mind could encompass the whole of that knowledge, was at an end. Gradually the number of years required to be spent in the study of the Science was increased, until today seven years must be devoted to preparation for the practice of medicine. Having achieved this goal, the young physician spends additional years in the study of some one branch of the Science.

As in medicine, so in other fields, specialization has been rapid and extensive. The nurse is practically a product of the last half of the nineteenth century, and yet today that comparatively new profession is rapidly being specialized. Tremendous progress has been made thus far and its future development is assured. In a like manner, we have witnessed the introduction of the social worker, the dietitian, the purchasing agent and other experts into the field of hospital administration. . . .

The advances and developments in medicine and consequently in hospital practice have been so rapid, but hospitals have experienced great difficulty in keeping abreast of the times. In some instances, development has been inhibited by the weight of precedents and customs and our institutions have not been able to adapt themselves to changing conditions. In general, however, the rapidity of changing conditions and of methods to meet those conditions has been so rapid as to prevent the formulation and adoption of well considered and carefully planned programs of development. The plans and programs of the past can scarcely be considered other than temporary and emergent. As such, it was but natural that they should often fail to adequately meet the situation. During the recent great emergency that confronted our nation, we were prone to criticize our government for lack of foresight and because the plans that were made were often inadequate. In a similar way, our plans and programs in public health affairs in the past, may be criticized. The redeeming feature, however, is the fact that progress has been made, and if in all matters pertaining to the public health, we could hope for the same degree of success as that achieved by our government, we could face the future most cheerfully.

"As we go about our daily duties occupied with things needful to be done, busy with little things and planning for the future, our colleague's problems and viewpoint are easily forgotten or overlooked. We stand with our backs to the circle and gaze out upon our own sector of the horizon, seeking the solution of our problems as we alone see them. There is therefore need of frequent council with our associates. There should be in every institution, frequent conferences of department heads. Here we should meet for the discussion of our problems. Here, as we stand about the circle, is the opportunity to face inwards and focus our vision on the common problem. Here is common ground upon which we should meet with an earnest endeavor to pool our interests and seek the solution of our difficulties in a manner that will work to the good of the entire service."

There is, however, great need for concerted action and a change of methods in our work. As has been said, we are in the midst of an age of specialization. Numerous specialists have been introduced into the field of hospital administration, not only in the professional departments of medicine and nursing, but likewise in the executive and domestic divisions. The greatest disadvantage in specialization is the fact that the specialist is so apt to become egotistical and illiberal and to seek to develop his specialty without regard for others or for the common problem. The chiefs of the various departments are inclined to develop petty jealousies and dislikes and to feel that more attention than is proper is being paid some department other than their own. The nurse is frequently the one assailed. She is the one who makes the various requests for service. The food is not properly prepared; the linen is not clean, stains have not been removed, it is torn or the quantity is not sufficient; the various supplies are not of proper quality; the temperature of the ward is too high or too low and a request for service or a complaint is registered. Similarly, complaints originate between other departments. Irritability, friction, and discord result, with a consequent diminution in the general efficiency of the entire institution.

Another result of this great specialization has been the organization of many societies. These have in most instances developed into local, state, sectional, and national organizations. Each organization, without due

*Excerpts from paper read at the Ohio Hospital Association meeting, Cleveland, O., May 16-20, 1921.

consideration of the common problem or of the other interests involved, is likely (as has been the case in several instances in the past) to develop its own program. Duplication and overlapping, with waste of effort ensues and we again have conflict and confusion.

These are some of the conditions that exist, some of the problems that confront us each day, that obstruct our progress and prevent the development of our programs or the formulation of well balanced plans. We stand in a circle, but we are each of us facing outwards and are directing our vision to our own particular objectives, we naturally draw away from our associates and the circle is gradually broken. We need to face about and focus our vision and thought upon the common problem.

The war taught many lessons, and not the least among them, was "the value of team work." There are those who bemoan the fact that the millennium did not immediately follow the armistice. We were fighting for democracy, for justice, for equality. We looked for a changed world to follow the war, and when we awoke the day after the armistice, and found the same old world, many were disheartened. But Rome was not built in a day and the changed conditions we looked for are still inevitable. The world can never be the same again, but the period of readjustment and reconstruction is always most difficult.

Relaxation After Armistice

After the armistice, came the general relaxation and soon our old prejudices returned. The emergency was over; we were exhausted by the strenuous effort and sacrifices and the team "broke training." But the nation has had an experience and a lesson. We are seeing more cooperation, more real team work in all fields of endeavor today than heretofore, and it is my opinion that we are to see more of it in the near future.

As I said before, hospital methods and practices have not kept pace with scientific progress. The general average of efficiency has been low. Thoughtful men were thinking about it and five years ago their thought culminated in the standardization program launched by the American College of Surgeons. The war interfered to a certain extent with the progress of that program and developments were slow, but the work did not cease. After the war, other organizations, interested in one phase or another of hospital work, began to draft similar programs. Often these were without particular consideration for the work undertaken by some other society and duplication and overlapping resulted. Our mails became heavy with inquiries and questionnaires. Visitors and investigators called to interview and inspect. These various programs were no doubt in many instances inspired by the one first launched by the College of Surgeons and while their purposes were excellent, they were leading to chaos.

Again, men of wisdom, saw the value of team work and through the organization of the American Conference on Hospital Service, sought to furnish a common ground, whereon all associations interested in hospital service and in public health affairs, might meet for the discussion of the common problem—the improvement of hospital service. This conference has had several meetings and holds forth great promise of future good. It should and will, I believe, serve as the mechanism whereby constructive and correlated programs for the future may be developed. The last session of the Conference was held in joint session with other bodies interested in medical education, nursing education, licensure and public health and gave evidence of just such spirit. This is an excellent start by our national associations, and promises much for cooperation and correlation of effort on the part of those societies.

Another effort along similar lines was inaugurated last year in the organization of the Ohio Public Health Association. Through this society it is hoped to unite all those agencies in our state that are interested in matters pertaining to the public health, and to furnish them with a common ground for the discussion of state problems. At the same time, it is the desire to organize, under this state association, district and local bodies of similar nature. It is not intended that any of the cooperating or member societies shall lose their identity or independence, but that there shall be developed a voluntary health organization, paralleling the official state department of health, that will work with that organization for the promotion of public health. We therefore have state and national associations directing their effort toward closer cooperation and better team work.

Our individual institutions are the foundation upon which these societies have been erected. It is therefore of vital importance that each hospital develop an intact and harmonious organization. If we will but work to that end, progress in state and national programs will be all the more rapid. This, however, is only one reason why each member of the hospital personnel from president of the board of directors, superintendent, directress of nurses, on down through professional, executive, and domestic divisions to the most menial employee, should exert every effort to promote harmony and correlate their work.

Regardless of size, type, specific purpose or peculiar organization it is the primary function of every hospital, to care for the sick. This is our most important and our common problem. I have often wondered in recent years, whether we are not permitting this, our primary function, to be submerged while we strive for higher standards of one kind or another in special fields. Education and research are functions of the hospital, but they must never overshadow the primary one. Higher standards are essential but we must not lose sight of the very reason for our existence and neglect the patient who is consigned to our care.

Organization Essential for Success

The work of caring for the sick in our institutions will be most efficient when we act upon the principle that the important problem is the organization of that work, rather than the mere selection and election of persons to be employed. The organization may readily be compared with that of a professional baseball team, with its board of directors and manager. The application of the simile is easily made. Physician and nurse, are like the pitcher and catcher. They are in constant demand and it is their work that stands out most prominently in the end results, and that has so much to do in establishing the reputation of the institution in the minds of the people. Other departments are like those players who form the infield, they are second in conspicuousness and their support is most essential. Then there are others, like those who play in the outfield. Their services are only in occasional demand, but it is of extreme importance that they be prepared to serve when called upon. Perfect team work is just as essential for success in our institutions as it is upon the athletic field, but in our case its importance cannot be overemphasized, for we are engaged in the all-important contest with life and death. Each of us, no doubt, has witnessed or heard of the defeat of the athletic team composed of "star performers" or experts, at the hands of a team composed of more or less mediocre players. We did not have far to search for the reason of such defeat. Experts and specialists in every line of endeavor, seem to possess an uncanny faculty of developing sensitive dispositions and temperaments. It is a known

fact that they find cooperation more difficult and that only too often they cannot work together. It is because of this that they are so often defeated when opposed by a group of individuals, whose personal abilities may be inferior, but who have learned the value of concerted effort. As administrators we are constantly being impressed with the importance of personality and temperament.

As we go about our daily duties occupied with things needful to be done, busy with little things and planning for the future, our colleague's problems and viewpoint are easily forgotten or overlooked. We stand with our backs to the circle and gaze out upon our own sector of the horizon, seeking the solution of our problems as we alone see them. There is therefore need of frequent council with our associates. There should be in every institution, frequent conferences of department heads. Here we should meet for the discussion of our problems. Here, as we stand about the circle, is the opportunity to face inwards and focus our vision on the common problem. Here is common ground upon which we should meet with an earnest endeavor to pool our interests and seek the solution of our difficulties in a manner that will work to the good of the entire service. Petty jealousies, personalities, and the various elements that go to cause discord must be carefully excluded, otherwise such conferences will do more harm than good and will only result in failure. Fair consideration must be given the administrator. He, too, has become more or less a specialist and is likely to develop a "temperament." But he, too, must learn with his subordinates the meaning of the word "cooperation". That it does not always mean "do as I say or direct" without regard for viewpoint or reason. That it does mean a whole hearted effort to work together in order that the greatest good, the highest efficiency may result from combined effort.

If we can practice such team work and never before in the history of the world has team work and close correlation of effort been so needful, we need not fear the future and its programs and problems, nor that the efficiency of our institutions will not be increased.

DIETOTHERAPY*

By LULU G. GRAVES, Professor of Home Economics, Cornell University, Ithaca, N. Y.

THE subject of dietotherapy today, is so new and has so many specific branches that it would seem presumptuous in one to try to discuss it under such a general title as has been given this paper, so I shall begin by speaking of dietetics instead. The terms, "dietetics" and "dietotherapy," are used somewhat loosely because of their close relationship, but there is a distinction. Dietetics pertains to proper feeding of anyone—sick or well, doing hard labor or leading a sedentary life; dietotherapy pertains to the treatment of disease by diet and implies a more highly specialized training than does dietetics.

DIETETICS AND DIETOTHERAPY

"Dietetics pertains to proper feeding of anyone—sick or well, doing hard labor or leading a sedentary life; dietotherapy pertains to the treatment of disease by diet and implies a more highly specialized training than does dietetics.

"Both of these subjects are of interest to dietitians, since we are concerned with the promotion of health as well as the treatment of disease, and the center of interest of these groups is found in the hospital clinic. The hospital was the first institution to employ a dietitian, but for many years she has been a more or less negligible factor there. Recently, however, in some of our more progressive hospitals there has been a decided change for the better in the status of the dietitian and we hope a little leaven will leaven the whole lump."

Both of these subjects are of interest to the medical and nursing professions and to dietitians, since we are concerned with the promotion of health as well as the treatment of disease, and the center of interest of these groups is found in the hospital clinic. The hospital was the first institution to employ a dietitian, but for many years she has been a more or less negligible factor there. Recently, however, in some of our more progressive hospitals there has been a decided change for the better in the status of the dietitian and we hope a little leaven will leaven the whole lump.

Nothing in the entire organization of the hospital touches everybody concerned with it as does the dietary department. The patient may receive the best possible medical care, but if he is dissatisfied with the food served to him, he will not be a booster for the hospital; the nurses may get a training which is unsurpassed, but if their food is not good, they will not always speak in loyal terms of the institution; the employees will not give their best service if they are not well fed; and so on through the whole system. Yet until recently the dietary department was given little or no consideration by anyone—from the board of directors to the kitchen employee. And now that a number of hospitals are realizing the value of good service in this department, we have almost no one trained to give it, and no place where one can be trained in a reasonable length of time. At present there is no provision whatever for the proper teaching of this subject to the thousand or more women sent out from our colleges every year. This is one of the weakest spots in the whole educational system at this time, when there is such great need of raising the standard of the nation as a whole, in the knowledge of nutrition. Our home economics schools are not prepared and they do not know the situation, either in large group feeding or in the treatment of disease by diet, well enough to do what is needed; our medical schools feel that their curriculum is already overcrowded and are not willing to make radical changes yet; hospitals which have been built for any length of time are not yet equipped to offer such training as should be given.

Another point deserves consideration. In practically every walk of life there is being shown an intelligent interest in health, and diet in relation to health. Mothers and housewives are eagerly asking for information that will help them to feed their families better. From the public health centers, dispensaries and schools there come continuously, requests for help. How are we going to meet this with reliable information? It is a well estab-

*Read before the American Conference on Hospital Service, Chicago, March 9, 1921.

lished custom to rely upon the doctor and the nurse for any information relating to the care of the body, and most deservedly so, but dietotherapy is such a new subject that we have comparatively little authentic information to offer. Nutrition experts have helped us much, but not everyone is in a position to profit by their work. The majority of medical men have had neither the time nor the opportunity to study this subject thoroughly. Their knowledge of food composition is frequently confined to percentage values as published in tabulated form. They know little or nothing of changes in composition which may take place during cooking, methods of cooking, and other important factors. It is not necessary for the doctor to have a course in home economics, but he should know some of the fundamental principles of food composition, and the effect of improperly cooked food upon processes of digestion. Nurses all too often are given only ten or twelve lessons of two hours each in this very important phase of their work. With this meager training they are expected to meet the demands of the physician and the needs of the patient. That this is impossible is obvious. Dietitians have no opportunity to learn the fundamentals of diseases of metabolism which are necessary in order to make practical application of their knowledge of foods until they are out of college, and then while they are struggling to adjust themselves and their training to an entirely new world, they need someone with patience to help them. How can we get together in this? Is not the hospital the logical medium?

Must Improve Education

The hospital offers postgraduate work of a most valuable kind to the medical student, not a few offer postgraduate work to nurses, and some are offering a training to dietitians. In only a few hospitals, however, is there any standard or even a prescribed course for student dietitians. In the majority of instances she is given an opportunity to learn something of hospital technique, a superficial knowledge of diet for special diseases, and preparation of formulas for infant feeding, but seldom does she get more than this. In the past three or four years too many hospitals have offered student training for dietitians simply as a means of helping to relieve their difficulties due to shortage of nurses and labor. The medical and nursing staff have accepted her on these terms, her time is devoted to routine work and she is giving the institution an inadequate maid service, when she might be giving intelligent cooperation in a most important phase of medical service. Hospital superintendents, medical men, dietitians, nurses, and patients agree that the present situation in the majority of our institutions is much to be deplored, and all would welcome an improvement. Shall we not give some time and thought to the way in which this improvement may be brought about?

A large number of hospitals are just now in process of construction or in contemplation, so this would seem to be the logical time to take some definite action toward getting a closer contact between medical schools, hospitals, and schools of home economics, for the purpose of acquiring more knowledge and thereby being enabled to be of greater service in this branch of medical therapeutics. A few hospitals are establishing metabolism wards and nutrition clinics which will be excellent both for training and for furnishing valuable data. No doubt you know of the hospital recently opened at Rochester, Minn., in connection with the Mayo brothers group, which is to be devoted to metabolism work. It has a service which is rapidly becoming established and which promises well because of the interest and cooperation of all engaged in it. Each doctor in charge of an individual service—stomach cases, diabetes, etc.—and the dietitian, have a conference every morning. The importance of this is evident. In addition to the metabolism ward there is an out-patient restaurant which bids fair to become a valuable feature. They are just now ready to offer a six months' training for dietitians, and the plan for the future includes placing dietitians in all of the other hospitals of the group.

It is gratifying to know that the College of Medicine in the University of Iowa has established a department of nutrition for next year. Dr. Ruth Wheeler, a woman with recognized ability, has been chosen to do this work. A letter received a few days ago from a member of the faculty states that no definite information with regard to plans is yet ready for publication, but "something distinctly good" is being planned.

At Ithaca the senior girls in home economics who expect to become dietitians are given a little insight into their future work through an affiliation with the medical advisors of Cornell University, and with the public welfare department of the city. The medical advisors on the campus send to my office students or members of the faculty needing dietetic treatment, giving me the diagnosis, history, and any other pertinent facts. I prescribe for them, and the students in my class prepare the food required for their treatment. Frequent round table discussions enable each member of the class to learn what is being done by other members treating different diseases. This practical knowledge is of great value to the girls, the students treated have the benefit of real dietotherapy, which would be practically impossible in the eating places in and about the campus, and the medical advisors are very cordial in their expression of appreciation for the work of our students. It has been successful from every standpoint as far as we have gone. It is by no means an adequate training for dietitians, but it is merely a move in the right direction. One of the valuable features of the whole arrangement is the impression being made on the student body. They have evidence constantly before them of the importance of diet in relation to health, they have learned that nutrition, dietetics, and dietotherapy are sciences and are not to be classed as unskilled labor in the kitchen.

Needless to say, these evidences of progress in education in dietotherapy are more than pleasing, but we need to have them multiplied many times. It was with the hope that we might develop a higher standard in the dietary departments of our hospitals and have only well trained women in charge of them, that the American Dietetic Association was organized. Anyone who attended the third annual meeting of this Association cannot be pessimistic about the future of dietetics and dietotherapy. The question is how to get quicker and better results through united effort. The Association was organized by and for hospital dietitians, but we now have representation of every phase of nutrition and dietetics. Our membership of about five hundred is made up of enthusiastic workers, eager for better and broader education which will help to put this profession upon a higher plane.

Doctors See Need for Education

An editorial in the *Journal of the American Medical Association*, December 4, 1920, on "Neglected Possibilities of Dietotherapy," indicates that doctors, too, are anxious for a better knowledge of this subject to be disseminated. May I quote from the last paragraph, referring to cases given, "The success of dietary undertakings of the char-

acter reported depends in no small measure on a knowledge of food requirements. The quantitative aspects of nutrition must be cultivated to a larger degree than heretofore, and with greater personal enthusiasm and appreciation, if progress is to be made in practical dietotherapy. It is futile to speak of calories or fuel value or nutrient units so long as they convey no concrete idea to the medical mind. Nor do grains and drops and diopters avail so long as they remain mere words in the physician's vocabulary. Nutritive needs must be realized in terms of edible foods, else they will mean little more than glass lenses do to those untrained in ophthalmology. There is room for education and there is also great promise of success from the application of such learning."

An illustration of what may be accomplished through education of both professional and non-professional people is shown by the marvelous effect upon such diseases as smallpox and typhoid and others of like character. As you all know, finding the cause, and teaching people better habits of living in order to eliminate the cause, have reduced the prevalence of these diseases to a miraculous extent. It is conceded that a large percentage of diseases of metabolism are preventable through right habits of living and right habits of eating. I am optimistic enough to believe that education may proceed rapidly, and that in the future there will be brought about results with diseases of metabolism similar, if not greater than have been accomplished with communicable diseases.

Dietitian Being Taken Into Business

Commercial institutions and industrial organizations of numerous kinds are realizing the value of the woman with a knowledge of foods and nutrition in their lunchrooms and welfare departments. What has been done in the United States Rubber Company, what is being planned by the Eastman Kodak Company, and dozens of other firms equally well known, makes a very interesting story, though time will not permit the telling of it now. Even hotel men are beginning to give thought to this new development. In Chicago, the management of the Chicago Beach Hotel, realizing that their service for children was not what it should be, secured Miss Esther Ackerson to develop for them a dining room for children, in which they may be served proper food specially planned for children. Service to people needing special diets is also offered by this hotel. Other hotel men are asking for women trained in food and nutrition, but none are available. This is significant. It is a danger signal which we cannot afford to ignore. Now that the hospital and the physician begin to realize what dietetics and dietotherapy mean to the medical profession, and a widespread movement for the promotion of health and prevention of disease has accorded these subjects a prominent place in the minds of the non-professional, it is essential that the woman who does this work have the best possible training for it. The business man sees this and offers far greater inducement to the well equipped woman than the hospital has ever offered. This does not mean salaries exclusively, though we are all human and know that money speaks with a loud, clear voice. Another point in favor of the business position is that in these institutions the dietitian is recognized as having jurisdiction over a department, and is given authority to carry through a piece of work as planned, regulations made by her are observed with the same respect that those in other departments receive. Furthermore, in the business world the dietitian has time and opportunity for contacts and interests beyond the four walls of her own domain. There are women with a good scientific background and an interest in their fellow men who much prefer dietotherapy to dietetics, even though the former offers a smaller salary, though there are not nearly enough adequately trained women to meet the present demand. During the past year four of our well trained, experienced dietitians left the hospital field to go into commercial work. Are we content to go on as we have for many years accepting the mediocre when we should have the best?

Through combined efforts much can be accomplished. A modern, up-to-date hospital, a progressive medical school, and a good, practical, scientific course in home economics would produce the persons who could do this work as it should be done, either in the large institutions or in any other place where nutrition of the individual should be considered. We should have a hospital which is educational. Let the education be spread through its out-patient department, pre-natal clinics, infant welfare clinics, wise instruction, demonstration, and follow-up work in all of these,—a training school for medical students, nurses, and dietitians, where postgraduate work could be done with great profit to themselves as well as to the institution. Let it be not a place where only the rich can go, nor a place starting with a wrong or a narrow premise, but a place where there is real interest in sane feeding and proper treatment of metabolic disorders. With this an established fact, home economics colleges and medical colleges would have to conform.

NEW TUBERCULOSIS HOSPITALS

An outline of the construction plans for the tuberculosis hospitals so much needed for the treatment of ex-service men will soon be published by the United States Public Health Service; and it is earnestly hoped that funds for their construction will soon be available.

In the preparation of these plans, which are believed to embody the best principles of sanatorium construction collected from a multitude of sources, valuable assistance has been rendered by T. B. Kidner, of the national tuberculosis headquarters. Mr. Kidner has been on duty with the Public Health Service for several weeks at a time, at intervals during the year, and the results of his study will be described and illustrated in the outline about to be issued. Copies of the publication may be had by application to the Surgeon General of the Public Health Service.

VOLUNTEERS RELIEVE NURSING SITUATION

The great shortage of nurses that has been threatening the hospitals of New York City is being met in a unique way by women who in ordinary life belong to the leisure class. Two hundred volunteers have been organized by the New York County Chapter of the Red Cross, and placed on duty in fifteen of the largest hospitals.

By taking over such tasks as washing patients, wheeling them to and from the operating room, making beds, checking laundry, and taking the histories of patients, they are releasing scores of nurses for more difficult duties. A large number of women who took Red Cross courses in home nursing during the war are acting as nurses' aides, doing practically everything the nurse does in the wards except give medicine.

Red Cross workers have also taken over the making of surgical supplies and hospital garments in a number of the hospitals. Though they receive no pay for what they are doing, many of them give full time. Others give two or more afternoons each week. New volunteers are coming in at the rate of fifty a month.

MANCHESTER BUILDS A MEMORIAL HOSPITAL

THE story of the Manchester Memorial Hospital, South Manchester, Conn., is a remarkable one. Manchester's whole war record was a proud one; in every drive for money, her citizens doubled and trebled their quota. After the armistice was signed and the question came up of a proper memorial to the men and women who served in the great war, it was suggested that a hospital would be a most fitting tribute, and an institution which would fill a present need. The idea was taken up at once.

When it was announced that this would be Manchester's final tribute to her heroic sons and daughters, there was a veritable out-pouring of money. In the short space of one week $195,000 was contributed by the people in sums ranging from fifty cents to several thousand dollars. Something over 5,000 people joyfully registered their appreciation during the drive. That was in May, 1919; the hospital was formally opened on Armistice Day, November 11, 1920. From two o'clock in the afternoon until eleven in the evening, the new building was thronged with visitors. Previously the hospital had been dedicated by appropriate exercises in which the town officials, ex-service men, Red Cross organizations, etc., took part. One interesting feature was the setting out of forty-three trees, each being planted in memory of a man who had lost his life in the service. From the crowds who attended and the remarks that were heard, it was apparent that Manchester's new hospital was to hold an affectionate place in the minds of its citizens.

In the vestibule of the building on either side are two great tablets containing a roster of Manchester's soldiers and sailors of the great war. The dedication inscription reads: "This hospital is dedicated to the men and women of Manchester who served the town, state, and country in the great war of 1914-1918."

The hospital itself is in the Georgian style of architecture, of brick and limestone construction with white trimmings, it is one hundred and twenty-five feet long and fifty feet wide, and has a capacity of fifty-six beds. The plan is the result of careful study on the part of experts ably assisted by the local medical fraternity. Dr. Alexander Lambert and Dr. Walter Gray Crump, both of New York, very kindly offered valuable suggestions. One of the features which strikes one on entering the building is the unusual furnishings. A reception room and consulting room on the left are furnished with old fashioned colonial pieces, or reproductions of that period. The same is true of the private rooms, each one of which is distinctively furnished in a different color scheme.

The waiting room and committee room of the hospital.

The public wards accommodate twenty-four to thirty-six people, the maternity ward six to twelve, the enclosed sun porches making it possible to use the maximum number of beds. The operating room, delivery room, x-ray and plaster cast room are on the top floor, where the nurses' rooms are located temporarily. The nurses' rooms are large and light, and suitable for private rooms. It is the plan to use them in this way as soon as the money can be secured to build a nurses' home.

There is no intern at present at the hospital. The local physicians form the attending staff and treat their patients at the hospital by private arrangement. When a ward case comes in and no doctor is specified, the local men are called, in regular order.

One of the attractive sun-parlors at the Manchester Memorial Hospital.

The superintendent is Miss Delilah Gauthier, formerly assistant superintendent of Fordham Hospital, New York City. Although at this writing the hospital has been in operation but two months, it has several times been almost filled to capacity, and the organization is functioning smoothly. The present personnel consists of a superintendent, assistant superintendent, two night nurses, four day nurses, operating room nurse, two pupil nurses, a cook, and two helpers, and an engineer-janitor.

The management of the hospital is in the hands of a board of trustees elected by the people who contributed to the hospital fund. These are elected biennially for two, four and six years, respectively. Persons contributing $5.00 are members of the corporation for one year, those contributing $25.00 for five years, and those contributing $100.00 are life members and entitled to voting privileges.

Doctor Way of Wilmington informed me, that a certain Abner Cloud, who was reduced so low by a pulmonary consumption as to be beyond all relief from medicine, was so much relieved by sleeping in the open air, and by the usual toils of building a hut, and improving a farm, in the unsettled parts of a new country in Pennsylvania, that he thought him in a fair way of a perfect recovery.—Medical Inquiries and Observations (1809) by Benjamin Rush, M.D.

SELECTING THE PERSONNEL FOR THE SOCIAL SERVICE DEPARTMENT*

By A. L. SEXTON, M.D., Superintendent, Hartford Hospital, Hartford, Conn.

THE growth and progress of social service work during the thirteen years of its existence is nothing short of remarkable, but, judging from the present outlook, it is yet in its infancy. With the rapid development of this wonderful organization, have come progressive changes in the demands. The financial status of the country has in many instances changed the type of work.

With the present demand for labor at unheard of prices, the question of ignorance is a more potent factor than income. The time was when a social service worker's chief task was providing free hospital treatment for the sick poor, and employment for them when they were able to be discharged, but conditions have changed, the scope of her activities has broadened out, until now they are legion in their number.

We will only mention those that come to us most frequently, viz., procuring hospital care in acute illness, arranging convalescent care, procuring institutional care for types that cannot be cared for in the general hospital, nervous, mental, insane, incurable, incapacitated, etc., securing past medical and social histories for the aid of better and more comprehensive treatment for the present condition, supervising the care of children who have been discharged from the hospitals and allied institutions, providing and supervising special diets for convalescents, securing the proper care for neglected children, arranging for the care of children whose mothers have to undergo operations, or go to the hospital for any cause, arranging working conditions to suit the patient's physical limitations, supervising the wearing of apparatus, pre-natal and post-natal work, seeing that they have the proper dental care, teaching them how to take care of their homes and families in a hygienic manner.

Different Qualifications Needed

At a glance, one can see the tremendous strides that have been made, and how different must be the qualifications of the social service worker of today compared to a few years ago. The selection of the personnel of a social service department is a task that should entail a very careful appraisal of the individual's training, personality, powers of observation, sympathy, analytical judgment, and last, but by no means least, honesty of purpose. The woman who would make social service her life work must be one that can approach her duties as so many opportunities, and not as so many tasks. She must be one who can bring to her work a broad human sympathy that is tempered with keen analytical judgment. This, probably more than any other calling in life, requires individual thought and application. These people are each a law unto themselves, and the social service worker who clings to one method of applying all of her remedies just because customs and traditions have made them so, must fail in her attempt to meet the situation. You cannot approach these cases with your mind made up as to diagnosis or treatment, you must be guided by the findings in each individual case.

This brings us to the trained worker and what we mean by training. The best definition I know of this has been furnished by Mr. Michael M. Davis, in which he says, "A trained social worker means a person who has learned to make critical but sympathetic judgments of human problems, and who has also learned how these can be dealt with effectively in practice." He cites the following specific examples which require training and good judgment to solve: "Shall material relief be obtained for a family for three or four months, during which the father will be in an institution because of sickness, or shall the five children and mother be placed in four different homes of willing relatives during that period—a course to which the mother strenuously objects? Shall a delicate child with kind hearted but quarrelsome and uneducated parents be placed in a country home for six months, or shall an attempt be made, through the parents' love for the child, to reconstitute family life sufficiently to enable the girl to get well at home? Shall an unmarried pregnant girl of twenty-one be urged to marry the father of her child when the man is willing, but the girl has lost confidence in him, or shall she be helped to fight her battle of life alone?"

Here are three problems, no two of them alike. No two conditions can ever be identical in social service work. The physical or social conditions that give rise to these problems can never be the same. Here is where the personality of the worker comes most forcibly into play.

Human Sympathy Essential

No one should ever attempt social service work unless she is well educated, well grounded in psychology, and has a love for intricate social problems. The person who can bring to her work a personality that is ripened with experience and training need have no fear of insurmountable difficulties, but with these must ever be present that human sympathy that secures confidence and makes possible that insight into the real cause of the trouble without which there can be no remedy.

The time has come when social service must extend its activities into fields that a few years ago were unknown. I think it is safe to say that public health, social hygiene, visiting nurses' associations, the public school nurse, the dental hygiene nurse, the nursing in industrial plants are, the world over, all outgrowths of social service. They are more or less dependent one upon the other, their object is one and the same—the betterment of mankind. This end is reached naturally enough by the different routes pursued by each of the different organizations, but the relationship is so close that it is not possible to say where one leaves off and the other begins.

The campaign waged on venereal diseases during the war has been passed along to the public health nurse and the civilian institutions, and much of the good that will result from it depends upon how efficiently we carry out the program that has been laid out for us. This is not a very delightful undertaking, but when we realize, as we have been compelled to do, that such a tremendous percentage of our man power is at stake from this condition, there remains only one thing to be done. We must combat the evil with every available force, and one of the strongest forces in the world today with which to combat this evil is social service.

*Read before the Social Service Corporation of Hartford, Conn., Oct. 25, 1920.

This condition is no respecter of persons or localities, and the number of children that come to the Hartford Hospital suffering from infections which have been passed along to them by their fathers and mothers because of their ignorance is surprising. I may say that most of these are brought to us through the social service department. I know of no condition in the practice of medicine that requires a greater amount of care, or more heroic treatment, than the eyes of the children who become infected in this way. My injunction in these cases is always one and the same—save the child's eyes if it takes the services of every nurse on the ward. Teaching the people in these homes how properly to take care of themselves and their children is one of the jobs that requires the greatest amount of tact and judgment on the part of the social worker.

Suppose, for example, the mother becomes infected and in turn the children, and it is necessary to clear up the situation without the husband's knowledge of the real cause. To go to the husband for his cooperation would mean the breaking up of the home, a deserted wife and probably a family of small children infected with the disease. You cannot place the children in institutions where there are other children, no matter how solicitous you may be for them. You cannot take them into your own homes. What are you going to do?

Complexity Constantly Increasing

I dare say this condition is met with as frequently as almost any other one in public health nursing, and it is one that we are going to meet more often than formerly, for the people are now alive to these conditions. It is going to take the combined efforts of all the good thinking people in the country to rid themselves of this evil. This is just one of the many demands that is going to be made on the social service departments.

This is one of the good things that has come out of the World War. The Public Health Service has shown us for the first time to what extent the man power of the United States is affected by these conditions, and those outside of the profession can do just as much as anyone else to help suppress these vices, to rid the country of these evils, and make it a safe place for us and our children to live in.

There is another effect of the World War, however, that has been borne in upon us in such an unmistakable manner that we would anxiously pass it by on this occasion did it not form such a vital part of the work of the social service department, and that is the lowering of certain moral standards. While we are glad to say that it has been grossly overestimated, the number of illegitimates over the country has been enormously increased, and to say the least, presents a grave problem. Here, in our opinion, is offered the best opportunity for extremely delicate social diagnosis and treatment. Here again is presented the personal equation which marks each individual as a separate entity, and here, more than any other place in the life of the social worker, must we have keen analytical judgment and an unmistakable honesty of purpose. We must bring into play the broad element of human sympathy, and an absolute departure from the lines of least resistance. These cases do not mean only the study of the patients themselves, but their families, their friends, their occupations, their neighbors, and their relation to the community. No social worker can alone correct these wrongs; the most that she can do is to help the individual to help himself, by directing his progress back to the channels of correct living. When these cases come under our observation the damage has been done, and the great human problem is how we can best undo as much of it as possible. While this is essentially a moral problem, we must not lose sight of the educational side of it, nor that the mother's moral sin is not any greater than many others who are more fortunate in not being detected, nor is she any worse, or perhaps nearly as bad, as the man who is responsible for her condition. Because the sins of these unfortunates have been found out through their becoming mothers of illegitimate children does not presuppose that they are morally any worse than their more fortunate sisters who have escaped detection, and on this delicate point of differentiation depends whether or not they can be brought back. Their treatment as mothers must in nowise differ from the treatment necessary to all mothers; because they have erred does not modify the fact that they are human beings, and must go on living.

Standards of Measurement

A case of this kind should be measured by the same standards we use in the practice of medicine. We arrive at our diagnosis by comparing all conditions with the normal. The physician who does not recognize the normal when he sees it cannot recognize the pathological. The social worker must be able to select for this type of patient a life that will approach as nearly as possible to the normal of the mother's former social sphere, and must never lose sight of the fact that she is possessed of the same emotions as other human beings, that she must eat and sleep and work, and that her desires for recreation have in no way been changed by her condition. Taken altogether, she presents the greatest complexity of human problems with which we have to deal. It is a problem we will never be wholly without, and our nearest approach to it must come through the education of the masses, and this education must begin in the home. Our duty is to help them help themselves, to point the way that will be the least difficult for them to tread, for, do what we may, their task is not going to be an easy one.

INSTITUTIONAL MEMBERSHIP GROWING

Institutional membership in the American Hospital Association has been steadily growing without any special effort on the part of the Association. Most of the members come as a result of correspondence with and service to trustees. There are now three hundred and forty of this type of members. Gradually the Association feels that the advantages of this membership will become apparent, and that no extensive publicity campaign is necessary. Of course a large part of the advantages of having a strong national association will come to all hospitals alike, whether they are members or not, and it is true also that part of the advantages accruing from the growth of the Association, for which the institutional members are largely responsible, will be received by hospitals through their personal members, however, the Association feels that the more dignified position is one of participation in the responsibility and support.

A large part of the hospitals which are now institutional members, are using the service bureaus, and the other services offered by the association. Hospitals cannot be forced to take advantage of the opportunities given them by these facilities, but if they do not do so, surely it is their own fault.

"The most heroic achievements come from the nurses who are spiritually sensitive. These are the nurses who receive the greatest satisfaction in the profession."—Aileen Cleveland Higgins.

BRITISH OPEN-AIR HOME FOR CRIPPLED CHILDREN

By DOUGLAS C. McMURTRIE, Secretary, Institute for Crippled and Disabled Men, New York City

ON HIGH ground, about twenty miles from London, commanding a view of all the surrounding country, is the St. Vincent's Cripples' Home, at Pinner, England. Two of the most eminent orthopedic surgeons in England direct its treatment: Sir Robert Jones and D. McCrae Aitken.

The outstanding feature of the institution is its "open-air" policy, carried to the nth degree. The home has, in fact, no buildings whatever, with the exception of the administration buildings, the operating building, and the school room. The wards are all sheds, open entirely on one side. The children are never taken indoors, no matter what the weather may be. In case of driving rain or snow the upper part only of the open side of a shed is screened with canvas, but the lower four feet are never screened under any circumstances.

It is the theory of the medical authorities of the home that unhealthy conditions atmospherically usually result from failure to change frequently the lower air strata in living quarters. The school building, for example, which has the general appearance of the average structure, may be closed or open from a point four feet above the floor to the ceiling, but is always left open from below that point to the floor.

The simple sheds, the character of which is well shown in one of the illustrations, have another great virtue besides healthfulness—economy. Their construction cost per patient comes to about fifty dollars. This makes capital expenditure for a given ward capacity very small.

There are only six indoor beds for patients in the home. These are in conjunction with the operating room, and are occupied by children who have been operated upon. But the stay in these beds is never more than two days, the children being then sent back to the open-air sheds.

The medical authorities report that a case of common cold is never known in the institution. They argue against the wisdom of having an institution with indoor wards and open-air porches outside them, because of the likelihood of children contracting bronchitis in passing from one condition of atmosphere and temperature to another.

During eight years there has never been an epidemic except when four children went to an entertainment in the town and caught scarlet fever. But even this was checked before it had spread farther.

The capacity of the institution is 115, and it is now full.

One of the open-air wards of the St. Vincent's Cripples' Home, Pinner, England.

Of this total about 100 children are of school age, i. e., five to sixteen. For these primary education is provided in the school room for those able to get about; at the bedside for non-ambulent cases.

There are two subjects of industrial training, shoemaking and repairing, and tailoring. The shoemaking shop is attended for the full day by boys of sixteen and over, a half day by boys between the ages of fourteen and sixteen, the other half day being devoted to primary instruction. Attendance is, of course, conditioned upon the physical capability and strength. The shop makes all the special orthopedic boots prescribed by the surgeons. It makes all the regular shoes worn by the children, and it keeps all shoes of the patients and staff in repair, and likewise does the leather work on braces made for the children. The shop accommodates about twenty pupils.

The class in shoemaking and repairing at St. Vincent's.

In the tailoring class instruction is given to about ten boys between the ages of fifteen and eighteen.

The home at present takes boys only, but adjoining property has been purchased and it is hoped in the near future to erect a surgical home for crippled girls. The institution is Roman Catholic in administration, but provides for children of all faiths.

The finances of the institution are of especial interest to an American observer, because of the extent of public financial support. The average annual maintenance cost per child is $296,* while the grants received in many cases from the local educational authorities come to $304. In other cases which come under the poor law provision the grant from the local board of guardians is $180. Out of a total budget of $33,732 there was received from public authorities the sum of $25,036. Inasmuch as $3,964 was paid by families or friends of pupils, or by other voluntary societies, this left a difference to be made up from contributions, interest on investments, sale of shop products, etc., of only $4,732, or a little over 10 per cent of the total budget.

In the United States such a favorable financial situation would be inconceivable. In Great Britain it is accounted for by some unusually enlightened national legislation adopted within the past few years. A good many

*In the conversion of British into American money, during the course of this article, for the sake of convenience £1 has been arbitrarily assumed to be equal to $4.00. This is lower than the normal rate of exchange, but higher than the present abnormal one.

The class in tailoring at St. Vincent's.

years ago the National Board of Education was empowered to pay 50 per cent of the expenses of maintaining such special day schools or classes for physically defective children as the local educational authorities should see fit to establish. Grants were also made for the conduct of educational work only in residential institutions. This stimulated provision for the education of crippled children.

The next item of legislation called for grants by the Ministry of Health to local authorities of half the expense of any essential treatment for cases of tuberculosis, which, of course, included tuberculous affections of bones and joints. It is this provision which has made it possible for many crippled children at private institutions to be paid for by the county or county borough councils.

The indigent children, who come within the poor law classification, are paid for in part by local boards of guardians, but the maximum amount these boards are authorized by the Ministry of Health to pay (under statute 45846 Vict., cap. 58, sec. 13) is $180 a year.

About two years ago there was secured a splendid amendment to the education law, making it compulsory upon, rather than optional with, local educational authorities to provide education for physically defective children of school age living within their jurisdiction. If treatment was essential to proper educational results, this, too, was to be provided. If the child needed to go to a residential school, this also was authorized. All of this is paid for in the first instance by the local authorities, who are in turn reimbursed for half of the expenses by the national education authorities. One cannot overestimate the importance of this law to the crippled children of Great Britain.

SUMMER COURSE IN CURATIVE OCCUPATIONS

The New York Society of Occupation Therapy will conduct a summer training course in curative occupations at Byrdcliffe, Woodstock, Ulster County, New York, from July 6 to August 12.

The medical lectures will be grouped as follows: surgical and general medical, including cardiac, orthopedic, tuberculosis, and neuro-psychiatric.

Courses will be given in design, weaving, metal work, toy-making, elementary woodwork, wood carving, gilding and polychrome, basketry, knitting, netting, knotting, (macrame), pottery, simple garment making, needlework and stitchery.

The curative value of occupation has been demonstrated in military, in civil and state hospitals, and there is a growing need for more and for better trained teachers and aides in United States Public Health hospitals, tuberculosis sanatoriums, neuro-psychiatric sanatoriums, as well as in civil and state hospitals throughout the country.

This course has been planned to meet three definite and immediate needs:

First—To train teachers.

Second—To raise the standards of crafts already accepted as curative occupations.

Third—To develop and adapt new occupations.

In order to profit by the varied experience and judgment of both instructors and students, a series of round table discussions will be held—round table discussions of such problems as administration, keeping of records and data, prescription forms and their use by hospital staff and aides, equipment and materials, products and their disposal, remuneration of patients, student practice teaching, assistant teaching by patients, analysis and discussion of diversional curative and vocational occupations.

It is desirable that students who take this course have some knowledge or experience in craft or hospital work, or have had training in social service or nursing. No part time students will be accepted, although it may be arranged that a student who is a master of any craft, can specialize in some other course. Exceptions will be made only for aides in United States Public Health hospitals whose vacation is limited.

Tuition for the six weeks' course, including all materials, is $55. Board and room may be had at the Villetta Inn in Byrdcliffe (near the class rooms and work shops), for $18.50 per week. It is aimed to make it possible for a student to cover the six weeks' course, including tuition, materials, all living expenses, railroad fare from New York or vicinity, for about $30 per week, and to provide combined study and vacation in a beautiful country.

Byrdcliffe, a private estate of about 2,000 acres, is situated on the mountainside, overlooking the village and the beautiful valley of Woodstock, where a large artists' colony, the summer school of the New York Art Students' League, is located.

Application blanks for admission to the course may be obtained from Mrs. Cornelius J. Sullivan, secretary, New York Society of Occupation Therapy, 541 Madison Avenue, New York.

As the class will be limited to twenty-eight students, two divisions of fourteen each, applications should be sent in early.

Committee on Summer School: Dr. Alexander Lambert, Mrs. Howard Mansfield, Mrs. Lewis A. Eldridge, Mr. Fred M. Stein, Dr. George O'Hanlon, Miss Marion Taber, Mr. Henry R. Hays, Mrs. Cornelius J. Sullivan, chairman.

URGE DENTAL CLINICS

In France, the establishment of school dental clinics is often urged by writers and speakers on hygiene, and measures against dental caries are receiving wide attention. A member of the Paris municipal council proposed the introduction of semi-monthly examinations of the teeth of children in the primary schools and écoles maternelles (for children three to six years old). The matter was referred to the authorities concerned.—*Bulletin de l'Union International de Secours aux Enfants.*

Of more than 2,000,000 babies born alive in the United States every year, more than 150,000 die during the first month, and at least 500,000 before the end of the first year. Proper nursing of mother and child could reduce this mortality beyond estimate.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
132 E. 45th Street, New York City

THE MAIN ISSUES OF THE YEAR IN TEACHING*

BY ISABEL M. STEWART, TEACHERS COLLEGE, COLUMBIA UNIVERSITY, NEW YORK CITY

A YEARLY stock taking is rather a good thing in education, just as it is in business. By counting up all our resources and liabilities, we find out whether we are coming out ahead or falling behind. By taking down and sorting over all our stock of educational problems once in a while, we at least let in a little more light and air, and may perhaps get courage, some time, to dispose of a few of them before the next stock taking comes round again.

The last year has brought few new educational problems, but it has sharpened the issues in many of the old problems, and has brought a new spirit, less complacent, and more defiant of hoary old educational abuses which we have been carrying altogether too long. We are getting much more critical of our own educational methods, and much more willing to have our work measured and tested by accepted educational standards in other lines of work. The wide interest which has been taken in the work of the committee for the study of nursing education, the Cleveland Survey, and the surveys which have been made in some of the western states, shows that there is a real desire to get at the actual conditions in our schools and in our teaching, and to see what is wrong with them. This is a distinctly hopeful sign, for it is evident that without an accurate diagnosis of the disease there is not much hope of finding the right treatment.

University Affiliations Good Sign

Another hopeful sign is the growing interest in university affiliations, which promise a marked improvement in our teaching facilities and methods. This idea is winning converts steadily, even among the more conservative of our medical friends, and our equally conservative university authorities. The new developments in our pioneer university school at Minnesota, providing for a series of affiliating hospitals instead of one, and the plan for centralizing the teaching for several Cleveland nursing schools under one university school, both show that we are broadening our ideas of what a university school should be, and discovering new ways of extending its benefits and improving its teaching.

Most promising of all is the fact that a few people are beginning to realize that nursing education must be paid for and liberally supported, as are all other forms of professional education. The Johns Hopkins Nursing School has done a great service for all other nursing schools in launching its endowment campaign for a million dollars. Its literature and its newspaper publicity will reach thousands of people who never heard of such an idea before, but who will begin at once to think along these lines. The more schools seeking such endowments the better, not only for the schools, but for the education of the public.

In the face of these definite movements, all in the direction not only of progress, but of educational reconstruction, we need not be too much concerned with the reactionary movements which are being fostered by a few men with early Victorian ideas of women's education and pre-Nightingale ideas of nursing. The world has gone too far to be easily stampeded into a panic because pupil nurses are taught a little chemistry and bacteriology. This is not minimizing the dangers of the wave of reaction which is sweeping over the country, but rather reassuring ourselves that there are strong counteracting forces and tendencies which will eventually overbalance them.

Actual Advance Not Great

Coming down to the actual standards of teaching in the rank and file of nursing schools throughout the country, it is difficult to say whether we have moved ahead very much in the past year or not. The scarcity of pupil nurses has made it difficult to keep up regular teaching, and the continued long hours in most of our schools makes much of the teaching we do give unprofitable, because the students are simply not in a fit condition to study or to absorb much of what we give them. On the other hand, the fact that many hospitals are not attracting enough students, has made them a little more willing to put in instructors and pay for proper teaching in the hope of competing with the better schools. It is evident also that state inspectors and advisers are recommending the employment of instructors to bring poor schools up to standard. This all creates a growing demand for instructors which has not been at all adequately met.

One of the biggest issues in the teaching field is the question of how to attract nurses of the right type into this work and how to train them for it. Salaries have advanced considerably in the past year,—most positions now paying at least $100 a month and living expenses, while a number pay $125 to $150 for experienced instructors. The duties of the instructor are still rather unstandardized over the country generally, and this is helping to keep some women out of teaching work. It is difficult for

*Read at the twenty-seventh annual meeting of the National League of Nursing Education, Kansas City, Mo., April 11-14, 1921.

the hospital to think in terms of anything but ten hours a day and seven days a week duty for all members of its staff, and the fact that class preparation has usually been done in the past outside of duty hours, and in addition to heavy executive duties, leads many people to expect that the instructor will keep up this old tradition. Of course no instructor can stand this pace long, especially when she is expected to teach from six to a dozen subjects. It is most important that we should make an effort this year to get superintendents and teachers together on this problem, and outline a workable schedule of duties and hours which will be accepted as a standard for the average school. This will do a great deal to relieve the friction which is found sometimes between the teaching and the executive staff, and to make the work more attractive to intelligent young women who are so much needed in the teaching field.

The tendency toward specialization in teaching is growing. In addition to the teacher of the sciences and the teacher of practical nursing, we are having some requests for teachers of special subjects such as operating room work, obstetrical nursing, etc. In these cases, there is a combination of supervision, instruction, and executive duties. There is no question that teaching supervisors of this type are needed in every department of the hospital, to give the student not only classroom but clinical teaching in the special branches. We shall have to provide a special kind of training for such positions.

Have Administrative Duties Also

Experienced instructors are in many places taking over much of the planning of the educational work of the school, the keeping of educational records, the arrangement of lectures, and other duties. They are practically first assistants of the superintendents of nurses on the educational side, and many of these women go over eventually into training school administration. This is a perfectly natural evolution, and although it robs us of some good instructors, it gives us more superintendents of nurses who understand the teaching problems of the school, and who are able to share in some of the teaching themselves.

A new demand is coming from university schools of nursing for nurse teachers who are prepared to specialize in one or two subjects. A degree is practically required in such positions, and the teacher must be an expert who can hold her own with the other experts on the college faculty. Ambitious young women of ability and personality should be encouraged to prepare themselves for these university positions. If they develop executive ability as well, there is every opportunity for them to become the heads of some of the new university nursing schools which are cropping up everywhere. We are suffering very much at the present moment from a lack of just such highly trained women who combine teaching and executive experience with a good understanding of the workings, both of a hospital and a university.

The work of the visiting instructor is going ahead and is becoming a recognized means of supplementing the resources of the smaller and even of the larger schools. It is interesting to note that while some of our women are going from teaching into administration, others are leaving administrative positions to go into visiting teaching. The possibilities of home life, the freedom to arrange one's own time without the constant demands of a rigid institutional régime, and perhaps even more, a real interest in teaching, make this transition a natural one.

It is impossible to classify teaching and administration into two separate categories and to say that we are going to have specialists who will do nothing but teach, others who will do nothing but administer. It should be understood in every training school, that all members of the staff, from the superintendent to the head nurse, are teachers, all working for the same educational aims, and all sharing in the education of student nurses, both in the practical and the theoretical work. It is true that the instructors will carry a larger proportion of the teaching, but they should also be kept in close touch with the administrative problems of the hospital, and should have some share in these if possible, in order that the whole organization may move together without the constant pulling between the wards and the classroom which is sometimes found in schools today. It is difficult for the instructor to carry administrative responsibilities if she has a full teaching schedule, but during the summer when classes are discontinued, if she can relieve for two or three months for some of the supervisors, she will keep in much closer touch with the life and problems of the hospital.

On the other hand, I should like to say one word for the instructor who is struggling, often singlehanded to maintain some kind of a systematic schedule of instruction, in the face of understaffed wards, exasperated head nurses, and unreasonable doctors. When classes are constantly broken into to satisfy the demands of the hospital, when students are taken out of class again and again, or come late, because they cannot be released from the wards, when they come exhausted to class, and there is no time to study, how can an instructor keep up any kind of enthusiasm, or accomplish what she is expected to accomplish in getting creditable results from these students and in arousing interest and respect for their class work? The fault is, of course, in the whole system which makes the student practically the sole reliance of the hospital in getting its nursing work done. But unless the whole staff is willing to support the educational program and to stand for the student nurses' rights, it is impossible for the instructor to accomplish much.

Improvement in Course of Study

In regard to the content of the course of study, there seems to have been a steady improvement. The work is better organized, there is less of the scattering of courses through the three years, the preparatory courses are being strengthened, new subjects such as psychology, the history of nursing, and the social subjects are shown in a good many of the new announcements, and there is a better distribution of time among the different subjects. There seems to be no doubt that the standard curriculum has been of great service to the schools in framing their courses of study, and the fact that we have had to order a third thousand copies within about three years, shows that it is being used rather widely.

There is some indication that methods of teaching are improving also. A few schools are struggling to introduce laboratory teaching in the sciences, though this very necessary advancement is slow on account of the extra time involved and the cost of laboratory equipment. The clinical method of teaching medical subjects is making some headway, though here again, greater time and expense are involved. The lecture method of teaching is less and less used in other educational institutions and from our own experience in nursing schools we know that it is often most ineffective. The quiz or recitation is being used a good deal to supplement the lecture method and this is all in the right direction, though time again interferes with its being applied as extensively as it should be. More attention is being paid to systematic class work and to holding student nurses up to a reasonably high grade

of work, though one still hears frequently of students having missed a whole series of lectures or having been allowed to graduate without passing some of their examinations.

There is a gradual improvement seen in classrooms, in equipment, and in library facilities. Where arrangements are being made to have classes carried on in high schools and colleges, these advantages are much appreciated and tend to greatly increase the value of the teaching. No marked improvement in these respects can be expected till nursing schools have independent funds on which they can draw for proper teaching facilities.

We are fortunate in having a number of new textbooks which are a distinct contribution to our training school library. Among these may be mentioned Miss Bailey's book on "Mental Nursing," Miss Smeeton's on "Bacteriology," Miss Pope's new book on "Materia Medica," and Miss MacLeod's "Chemistry for Nurses."

One of the biggest problems in the teaching field is the supply of trained teachers. Although we have many women who are doing good work without any special preparation, and many who have had some previous training and experience in teaching, yet even these women feel the need of more study along the line of the subjects they teach, and more insight into the fundamental principles of teaching. In some way we must lay hold on more of our promising young students in the training school and get them interested in this fascinating field of work. I have found very often that the most enthusiastic teachers are those who were almost pushed into it in the beginning, and who would never otherwise have discovered their own teaching ability or the satisfaction to be gotten out of the work with young students. For this reason, I think it is rather a good idea to have selected senior student nurses to assist the instructor sometimes, in demonstrations or actual teaching, but I do not feel that this should be considered in any sense a training for teaching. Such practice work will not carry one far without advanced courses in the sciences and arts that one is expected to teach, and courses in psychology and the principles of teaching. There are many places where such courses are already available, and we need to make a decided effort within the next few years to develop new centers for the training of teachers of nursing in all sections of the country.

We ought to do more also for the teachers who are already in the field and who cannot go away for extended courses of training. Some of the city leagues have done a good service by arranging a series of classes or lectures on teaching for their members. Others have formed instructors' sections of the local league where teaching problems can be threshed out among the members themselves. In New York this winter we have included the head nurses in the teaching section and have devoted one evening a month to the teaching of practical nursing, taking up the following topics:

(1) What is a well trained nurse?
(2) What is good nursing? How can you arrive at the standards for judging it?
(3) How can you apply these standards in comparing different methods of practical work?
(4) What is a good method of teaching practical nursing?
(5) How should the work of student nurses be supervised?

The institute is another means of helping the teacher in the field. It is encouraging to hear that at least one institute in teaching is to be held this summer, in Ohio, and it is to be hoped that many more will be arranged.

The group of instructors all over the country is now becoming fairly large and I find them very anxious to get together more on some of these general problems and also for the discussion of their own teaching problems. It seems to me that we are quite ready now to form a special section of instructors within the National League which will draw into the League a great many new members, and which will also help to push forward some of these issues which have just been outlined. Most of our instructors are enthusiastic and vigorous young women who want to work, and who need to be given some special task in our organization which will develop their powers and help us in building up the work of the organization. They can do this better, I think, if they work as a group within the National League, as they do in some of our local leagues.

The issues of the year in teaching have been many, and we seem to have made little impression on some of them. Perhaps the biggest thing is that we are getting more and more conscious of what has to be done and more intolerant of makeshifts and delays. If we can mobilize our forces better and get down to specific programs, there is no doubt whatever that, within the next year or two, our yearly stock taking will show a much higher total of positive assets and fewer liabilities.

ANNA CAROLINE MAXWELL

GREAT and widespread is the dismay at the news of the retirement of Miss Anna Caroline Maxwell from the directorship of the School of Nursing of the Presbyterian Hospital, New York. Not only among her own students and graduates, to whom she is "Our beloved Miss Maxwell," but among people far and wide who are interested in the nursing field, is the dismay felt. And yet on her retirement from the confining duties of a training school executive she will find many channels which will give her greater freedom and make her more than ever indispensable to nursing activities. Her friends and followers are glad, too, that this greater freedom will allow her leisure and increased opportunity for travel.

Miss Maxwell was born in 1851, at Bristol, N. Y., Her father, John Eglinton Maxwell, came of a distinguished military family in Scotland, where he was born, and was an ordained clergyman. Her mother, Diantha Caroline Maxwell, was born in America, of English descendants.

Miss Maxwell's education was carried on at home under tutors, with, later, two years at a boarding school. In 1874 she accepted a position at the New England Hospital, as assistant matron, and received here three months' obstetrical training. She herself has described, in an article called "Struggles of the Pioneers," in the February number of the *American Journal of Nursing*, some of the hardships which pupil nurses in those days encountered. Twelve hours service, including the most menial labor, was required, with one afternoon off a week, classes, when time was found for them at all, were in the evening and there was no time for quizzes or class discussion. The doctors did not approve of telling the nurses the method of treatment or the contents of the medicine being given, explaining that if they knew what results to expect, they would imagine them.

A recent picture of Miss Maxwell sitting at her desk

In 1876 Miss Maxwell entered the training school of the Boston City Hospital, being graduated in 1880. Here under the guidance of Linda Richards, the first American graduate, and a woman of rare intelligence with a vision of the future of nursing, she learned the first elements of scientific training. The conditions in training schools at this time were as difficult as those in hospitals. Miss Maxwell says in the article already referred to, "On entrance to the school I was escorted to a small room off a woman's ward, containing four beds, two bureaus, two chairs, pegs on the wall for costumes, and the use of a lavatory and bathroom shared with the ward. When we retired, we pushed the beds apart to get in, and sometimes entertained a stray night nurse who occupied the bed by day."

Dr. George Rowe, who for many years was superintendent of the Boston City Hospital, noticed the unusual qualifications which Miss Maxwell possessed for her vocation, and the enthusiasm and interest she brought to it.

Upon her graduation she was called to establish a school of nursing at the Montreal General Hospital in Quebec. Conditions there were almost hopeless, and as the managers and doctors were not willing to make the concessions necessary to establish a school on a proper basis, the plan for a school was given up.

Miss Maxwell then went to England, where she inspected the hospitals, and upon her return took charge of the training school which was connected with the Massachusetts General Hospital. In 1889, after eight years at the Massachusetts General, she was called to complete the organization of the training school at St. Luke's Hospital, where she carried on the work successfully until 1891.

At this time she was offered the appointment to establish the school of nursing at the Presbyterian Hospital, New York City. The cooperation received from the superintendent and president of the hospital, and the chairman of the committee on the school of nursing, made possible the establishment of a school on broad lines. The high educational standard which was set up then has always been maintained.

During the Spanish-American War, in the summer of 1898, a typhoid epidemic broke out at Camp Thomas at Chicamaugua Park, Georgia, where 50,000 men were being trained. Miss Maxwell was given leave of absence from the hospital to take charge of the nurses at the Sternberg Hospital, just being opened at Camp Thomas. One hundred and sixty nurses were sent to the camp and did a remarkable work, under Miss Maxwell's distinguished leadership.

When the World War broke out, securing the personnel for the Presbyterian Hospital unit fell to Miss Maxwell, who accepted the position of chief nurse. When we declared war on Germany, and the need came, it was thought that Miss Maxwell was needed most in this country, although she visited the war region twice, in 1916 and 1918.

During these years the Presbyterian School of Nursing continued to advance, and due to its policy of making the school as truly educational as possible, it has always been one of the first to introduce reforms, and has attracted the best type of student to its ranks.

In 1917, the governors of Columbia University conferred upon Miss Maxwell the honorary degree of Master of Arts. Miss Maxwell brought about the formation of the committee to establish an Eastern Council of Nursing Education, which was ratified on April 18, 1921.

Miss Anna Caroline Maxwell in her first nursing uniform

In the midst of her many duties and the important claims upon her time, Miss Maxwell has never failed in her sympathy for her pupils or for any nurse seeking advice. It is small wonder that when word of her retirement was sent out to the graduates, 400 of the total of 736 gathered to honor her at the commencement exercises on May 19. It was an impressive sight, the long procession of superintendents, head nurses, and graduates in uniform. The board of managers have been most generous in their efforts to show their appreciation of Miss Maxwell's work and presented her with an engraved diploma, expressing their high regard for the "school's founder, and guiding spirit for twenty-nine years."

The graduates had their opportunity to further honor Miss Maxwell on the day following commencement, Alumnæ Day, when, after a luncheon, a representative of each class made its tribute in a short speech. Miss Mary Magoun Brown put into words this final message of love and reverence, which she offered to Miss Maxwell with a bouquet of roses which concealed a check for $4,000, "for a little spree." The musicians played "For She's a Jolly Good Fellow," but at first no one could find voice to sing.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU GRAVES,
Home Economics Bldg., Cornell University, Ithaca, N. Y.

NUTRITION PROBLEMS*

BY MISS ANNA L. DEPLANTER, IN CHARGE OF NUTRITION WORK OF THE CHILD FEDERATION, PHILADELPHIA, PA.

IT IS scarcely necessary to state that nutrition and malnutrition have been brought before us recently as vital subjects, not because malnutrition is more prevalent today than formerly, but because the World War opened our eyes to general health statistics in America. Many factors have contributed to a better knowledge of our health standards, or lack of standards, but two stand out prominently:

1. Result of examinations of our soldiers for the army.
2. Result of the Weighing and Measuring Campaign during Children's Year for children up to school age.

Physical examinations in the army showed that 33 per cent of our men who should be at the height of physical prime were below par. The majority of the men in this "physically unfit" class might have been "physically fit" if attention had been given to the finding and correction of physical defects in the early years of childhood and adolescence. In other words, health supervision when they were children could have made vastly different physical records for our men of military age.

In the Weighing and Measuring Campaign during Children's Year, we found 15 to 30 per cent of our children under weight, and a much higher percentage on the border line. In some communities, such as the mill districts in Lowell, Mass., 75 per cent of the pre-school age children were found to be under weight. Figures varied in different sections of the country and in different parts of the same city, but malnutrition was prevalent to an alarming degree among rich as well as poor.

While much work has been done in nutrition studies for many years by public and private organizations, by individual doctors, pediatricians, and nutrition specialists, we have only been aroused very recently to the necessity of working on nutrition as a national and community problem. The whole country seems to be aroused to a need for action in this phase of health work. One of the most gratifying memories of the recent National Education Association Conference in Atlantic City was the fact that health seemed to be the most vital and fundamental subject discussed in every section program. When the approach to our many perplexing problems is definitely associated with health as a national asset, we are beginning to prepare the individual to more properly fit into his environment and take his place in American life.

Nutrition work is an important phase of a health program and one in which a group of home economics people is especially interested.

History of Nutrition Work

A brief summary of the history of nutrition work may be interesting at this point. The work began in hospital nutrition clinics. Here the physician was in charge and the follow-up work was carried on by a nurse, dietitian, or social worker. Dr. Emerson of Boston is one of the pioneers in this type of work, and the work of the nutrition clinic for delicate children is being extended to many sections of the country today.

Soon such organizations as the Red Cross, state departments of health, and state agricultural colleges began to take up the work. The splendid educational health propaganda work of the Child Health Organization gave much publicity to the work and has helped private and public organizations not only by its literature, but by the unique work of the Health Fairy, Cho-Cho and the Picture Man.

Recently the work has been taken up in the schools under the supervision of the medical department. It has often been introduced by a private or outside organization.

Pre-School Age Nutrition Work in Philadelphia

The Department of Public Health supervises nutrition up to the school age. There are about sixty nurses in the Division of Child Hygiene (which works with the pre-school age child).

The Visiting Nurse Society also works with the pre-school age child and has seventy-two nurses on its staff.

The annual birth rate in Philadelphia is about 42,000, so that each nurse would have approximately three hundred pre-natal and post-natal cases to care for. It is very evident that the 200,000 pre-school age children in the city do not get adequate health supervision, even with the work of other agencies like the Visiting Nurse Society, and the nurses who are associated with various hospitals and who do health supervision work in the city.

Other organizations who are working with the pre-school age child are the Babies Hospital, the Child Federation and Starr Center. The aim of these organizations, expressed in general terms, is health promotion rather than sickness cure.

As the school laws in Pennsylvania do not compel children to go to school until they are eight years of age, it is very evident that any attention given to the nutrition of the pre-school age child is accidental, because of the

*Read at the third annual meeting of the American Dietetic Association, Oct. 25-27, 1920, New York City.

small number of nurses compared to the number of children to be cared for.

We may well say that Nutrition Problem No. 1, in Philadelphia, is with the pre-school age child. At this age, health education is of genuine constructive value and is truly health promotion. Nutrition work with this group of children means less malnutrition in the public schools, and less remedial work. We must start with the prenatal mother and the pre-school age child if we are really aiming at health promotion work, rather than purely preventive and remedial measures.

Nutrition Work in the Public Schools

After children attend public schools, the health supervision comes under the Department of Medical Inspection. We have approximately eighty medical inspectors on half time, and eighty school nurses to supervise the health of about 240,000 children. It is very plain that there is little or no time on the part of these busy workers to give attention to nutrition.

The school lunches are indeed a valuable contribution to the health and nutrition of school children. Philadelphia has done splendid work in developing the hot school lunch and much good may accrue from the extension of this help in nutrition to a larger number of schools.

Other Nutrition Work in Philadelphia

Philadelphia Health Council: The Health Council is a private organization which is at present doing much work in schools. About 45,000 children are enrolled in the Health Crusaders, and in October, 1920, this organization began to do nutrition work in the schools. At present, nutrition classes have been established in five hospitals and five schools, with a total enrollment of 283 children.

Extension service of State College: One of the two extension workers in Philadelphia from State College is conducting nutrition work in the Campbell School. Miss Spalding has seventy children enrolled in her classes there.

The State Department of Public Health: Two clinics, one at Phipps Institute, the other at Seventeenth and Cherry Streets, also have nutrition classes. The classes are conducted along the same lines as those of the Philadelphia Health Council, i. e., according to the Emerson method.

The Children's Hospital: For the last five years some type of nutrition work has been done at this hospital both for the pre-school age and school age child.

The Child Federation: The aims of the Federation are health promotion and health education, and much emphasis has always been given to standards of work rather than volume. Nutrition work was first begun by the Federation in October, 1919, as a part of the work of the Fourth Ward Experiment. About one hundred children are in the classes now organized.

Lecture work in nutrition is being given to supervisors of the city health centers under the Department of Public Health, and also to the students at the Pennsylvania School for Social Service. This is a phase of nutrition work in which the Child Federation is especially interested, i. e., training of teachers, nurses, and social workers in nutrition, so that by their understanding and appreciation of nutrition facts they can better contribute to the nutrition and health problem.

In this brief summary of the nutrition work being done by other organizations, several factors which are vital problems in nutrition have been expressed or emphasized:

1. Inadequate number of nurses for nutrition work among pre-school age children and pre-natal mothers.
2. Need of more nutrition work in the public schools.
3. Need of more health and nutrition knowledge on the part of teachers, nurses, and social workers.
4. Inadequate dispensary care for children referred for correction of physical defects.

So far, general problems dealing with normal nutrition and malnutrition alone have been given. In dealing with malnutrition children we have many vital and specific factors. A full discussion of these problems is impossible in a general paper of this kind, but main points at least can be mentioned for consideration. Physical defects, such as carious teeth, enlarged tonsils and adenoids, and poor posture, are extremely marked among the malnourished children. The total number of physical defects in fourteen children recently examined for a malnutrition class was eighty-six. Fatigue is another cause of malnutrition. Many children fail to gain when physical defects and diet are improved, if attention is not paid to sufficient rest.

In the diet alone many factors may contribute to malnutrition. Perhaps the three main causes of poor nutrition with reference to the diet may best be summed up, in order of importance, as follows: (1) Lack of knowledge of food values and good food habits; (2) Lack of will power, or indisposition to follow correct dietary habits; (3) Lack of money to buy the right kind of foods.

Problems of Malnutrition

Specific food habits and problems to be met in correcting malnutrition are: (1) Emphasizing the importance of eating a substantial breakfast; (2) The tea and coffee habit; (3) Little or no milk; (4) Lack of vegetables; (5) Insufficient calories; (6) Lack of mineral matter; (7) Lack of vitamines (particularly Fat Soluble A); (8) Racial customs; (9) Religious restrictions.

In home economics work in the schools there are many opportunities for the teachers to emphasize foods from the standpoint of health. Are we sufficiently convinced of the importance of milk in the diet so that children of our classes leave with the resolve to take at least two cups a day? Do we so emphasize the value of vegetables in the diet that children will try to acquire a taste for them? Does each child in our class know her own height and weight standard? Do we denounce tea and coffee as one of the worst food sins of children and then teach them to make it "properly"? These are a few questions the teacher of cookery may ask herself if she wishes to join the ranks of those who are guiding children to health.

Let us concentrate on the well child rather than the sick. Let us also make health fashionable by putting it into the minds and hearts of children in such a way that following the "rules of the game" will not be a hard, irksome task, but a joyous and happy part of the day's routine of work and play.

CHAULMOOGRA OIL AND TUBERCULOSIS

The recent widely circulated statement that the United States Public Health had found that chaulmoogra oil was as efficacious in the treatment of tuberculosis as it had been shown to be in that of leprosy is said by Surgeon General Cumming to be unwarranted. Experiments made some years ago with the oil gave no definite results. Recent experiments with the ester, or derivatives, have been begun because of hopes based on some similarities between the bacilli of leprosy and those of tuberculosis; but these have not proceeded far enough to indicate what results will be obtained.

THE WIDER SCOPE FOR THE ADMINISTRATOR*

By EMMA H. GUNTHER, Assistant Professor of Household Arts, Teachers College, Columbia University, New York City

With the various specialized phases of work, all of interest to the dietitian, we are likely to ask which one needs greatest emphasis, and are reminded of the story about Mr. Carnegie, who, when asked, "Which is the most important factor in business—labor, capital, or management?" replied, "Which is the most important leg of a three-legged stool?" This thing is true, that the dietitian who keeps her range the widest and who is most alert to new developments, whether experiments in "human engineering" in connection with employee problems, cooperation with outside agencies, or with methods of studying types of organizations, that one is a dietitian in the truest sense of the word.

A recent bulletin has appeared with a striking front page, "Think beyond your Job," and it is this reaching out to see what the industrial manager is trying out, what the business man is proving, what the thinker is turning over in his mind, that is the cue for the administrator who is making progress.

Administrator Has Employee Problems

Employee problems face every administrator; new experiments are being tried; why not study them, visit plants, and decide whether any phase, even a small application, may be adapted to your field?

"Industrial Democracy" is a plan which was originated by John Leitch[1] to bring about better understanding between employer and employee, with the theme that "the best work a man can do is the work he does which has been urged not upon him, but which has been urged from within him." With this plan the workmen are represented by one body called the house of representatives, and another as the senate, with an organization similar to that of a cabinet, for the employee's representation. This close cooperation forms the working basis of the organization.

One of the New York firms trying this plan is James McCreery and Company, and a recent visit brought out some interesting facts in their organization. Through monthly bulletins, charts showing their "check-up" method, leaflets presenting ways and means of carrying out principles of "Justice, Cooperation, Economy," etc., one can become familiar enough with the method to see whether any of it or all of it may be applicable to a small institution. It is in studying experiments of this kind that one finds encouragement and zest for further study, and a "touch-up" in everyday living.

Experiments have been tried by firms in appointing employees as directors of the company—like that used in Procter and Gamble Company—where the employees share equal power with representatives of the firm.

Efficiency Depends on Mental Attitudes?

Robert Wolf's plan is based on the thought that most inefficiency on the part of employees comes from lack of interest. He points out that team work or *ésprit de corps* cannot be developed in an organ by artificial means, "It can only come where the creative power of the individual is freest to express his real inner spirit." In his book on "Common Sense and Labor Management,"[2] Neil S. Clark summarizes the various recent experiments in industry to bring about this closer relationship. A significant note was struck by Mr. Sam Lewissohn in the article on Industrial Leadership in the *Atlantic Monthly*, September, 1920, where he says, "We have laid too much stress on machines and processes and external forms of organization, and too little on 'imponderables'—mental attitudes of those on whom real efficiency depends." He makes a plea with those who are training such leaders, that more time and thought be devoted to the "modern technique of handling labor."

All administrators are seeking ways and means of attaining the best cooperation from employees, for we sense, with Kipling, that "The strength of the wolf is the pack, and the strength of the pack is the wolf." Team work counts, and the query is, how to obtain it. Every experiment tried in industry with large organizations should be studied, not only from the interest standpoint, but with the thought of possible adaptation in a small organization.

These are but a few, but why not choose such an interesting topic as this for study—a chance to "Think beyond your Job," and help turn some of the so-called drudgery into an interesting study?

It always works two ways, is of inestimable value to the dietitian herself, to give her new interests, and psychologically it strikes the right keynote, for if the results of such a study could be summarized and sent to your central office, the returns could be passed on to many others, and thus be far-reaching. It is one way to make for broad minded directors of all kinds of administrative work, whether in hospitals, cafeterias, dormitories, or elsewhere.

Cooperation and Centralization

What recent visits have you made in your vicinity to discover what experiments in cooperative methods are being tried? We hear cooperation on every side today, and as one expresses it: "Cooperation is the new thought. Time is not so far away when it will hold a big place as a workaday thought in the mind of every man. There is no magic about it. You cannot get and test results by going out today and buying it and installing it tomorrow, as you would a new machine."

One large business that has claimed great attention is the Bush Building, 130 West Forty-second Street, New York City, which states that "the two economic forces in the world are organization and cooperation. It is of, by, and for the buyer." Here, on the floors of a huge modern building, they have centralized materials and equipment so that manufacturers on the one side may display, and buyers, on the other hand, choose, with the best possible service to each.

What demands has the household administrator who is purchasing for large groups made of the special manufacturers? Could there be a centralizing of machines like dish-washers or washing machines so that a ready comparative study might be made? Is there a way to help economize in the matter of an inexperienced buyer? What is business doing, what are we doing, to help meet this?

*Read at the third annual meeting of the American Dietetic Association, Oct. 25-27, 1920, New York City.

1. Leitch, John: Man to Man, B. C. Forbes Pub. Co., New York.

2. Clark, Neil S.: Common Sense and Labor Management, Macmillan Co., New York.

Such companies as electrical testing companies are eager to get into close touch with those who have electrical labor savers, and wish tests made as to their efficiency. Are you cooperating?

This is another suggestive line of study that would be not only profitable to the individual, but if ways and means could be suggested for closer linking, a valuable contribution would be made to institution administration.

Linking Up with the Manufacturer

The question is constantly arising as to how far the work of the administrator should be linked with the manufacturers, or with business concerns today. Reputable firms are eager to have the best advice from users of devices and machines; the user of the device ought to familiarize himself more with the mechanics and methods of the shop and factory. Experts are employed in each department in business and manufacturing, and definite, accurate knowledge must be forthcoming. It is this very accurate knowledge of efficiency of parts, principles of machines, test processes, output, wear and tear, that the administrator should know. Standards can be maintained, and high ones, disregarding the stigma of the term "commercializing," and certainly interchange with manufacturers should be welcomed.

Where are our engineers among our administrative dietitians and cafeteria directors? Why not study not only what buyers and manufacturers are presenting today, but let your own kitchen be the most fertile of laboratories!

Graphic Charting Means of Study

One of the most enlightening ways to study your organization is by means of graphs or charts, and here again is an interesting home study that may be carried on in your own institution, and later, comparisons may be made with similar institutions in your vicinity. Willard Brinton, in his "Graphic Charts,"[3] presents in a clear-cut way, ways and means of "putting over" facts. Organization charts make for a much clearer understanding of the coordination of departments, and wherever one turns, good illustrations may be found of the use that is being made of such crystallizing of facts. It is said that "a chart is a mighty instrument for executive control," and more than one administrator in an institution has found it invaluable.

Gilman's "Charts for the Business Man"[4] has good suggestions. It would be worth while for a dietitian to collect various types of charts before making one for her own use; in studying the types used, one might turn to Y. W. C. A. reports where they make full use of graphs, to bureaus of social research, to Carnegie Foundation, to municipal bureaus, boards of health, etc.

No kind of study develops in a more interesting way, and especially if one finds her study reaching over into business organizations, getting into a realm that is in many respects so vastly different from that of the smaller departments. Yet this is just the method for growth. Read of these new experiments, study them, compare, and try to adapt them.

Work has to be viewed from a new angle to keep it fresh, and it is expressed by Christopher Morley, in "His Haunted Book Shop," when he says: "It is intolerable for a human being to go on doing any task as a penance under duress. No matter what the work is, one must shatter the old idea of it into bits and rebuild it nearer to the heart's desire. When one views a stubborn fact from a new angle, it is amazing how all its contours and edges shape. I have solved a whole kitchen philosophy of my own—a dishpantheism."

To the administrator, in large group living, we commend most earnestly the wholehearted practice of "Thinking beyond your Job"; of building week by week on some theme that presents itself in your kitchen as a working laboratory; of doing constructive thinking on a unit of work, no matter how small; of sensing that this is the way to vitalize the day's work.

3. Brinton, Willard: Graphic Charts for Presenting Facts, Engineering Magazine Co., New York.
4. Gilman, Stephen: Graphic Charts for the Business Man, La Salle Extension University, Chicago, Ill.

MAKING THE COUNTRY UNSAFE FOR MOSQUITOES

Dr. T. F. Abercrombie, health officer of Georgia, has suggested that the convict and other gangs who work along the roads be required to fill up burrow-pits, place culverts properly, clean ditches, and attend to other small but important details that any man can do and that will deprive the mosquito of many of her breeding places.

To accomplish this along the roads is more important than it may seem, for a mosquito hatched at the roadside does not have to wander in search of food; all she has to do is to wait for food to come to her. Moreover, if she is of the anopheline species, which spreads malaria, she has excellent chances both to acquire the malaria germs and to pass them along. Until she bites someone who has the disease, her bite, though no more pleasant than that of any other mosquito, is not any more dangerous. But a single malaria patient, driving along a ditch-bordered, mosquito-infested road, may provide hundreds of the insects with germs which they may pass on to every traveler along that road.

Dr. Abercrombie, by making the roads of Georgia safe for man, may materially reduce the malaria hazard of the state, and, according to the Public Health Service, his example deserves to be followed.

THE LEGAL STATUS AND PERSONNEL OF THE PUBLIC HEALTH SERVICE

Two of the points touched upon by Surgeon General Cumming, in the annual report of the Public Health Service, were the legal status of the Service, and the loss in personnel during the last few months. On the first subject the Surgeon General said: "It is believed to be of the utmost importance that the legal status of the Public Health Service in its war risk work should be firmly established, by placing an administrative head over the three major agencies involved, namely, the War Risk Insurance Bureau, the Federal Board for Vocational Education, and the Public Health Service, and that these three bureaus should operate under this head as coordinate and independent bureaus in close cooperation."

Concerning the loss of personnel, Surgeon General Cumming reported: "Despite the temporary increase in compensation granted by Congress during its last session, the Public Health Service, in common with the medical corps of the Army and Navy, finds it impossible to secure candidates for admission to the entrance grade of its regular corps, and the attractions offered its scientific personnel are such that the resignations have actually exceeded the admissions during the past twelve months."

New Zealand has established a national bureau of mouth hygiene, with a director and staff of assistants who will care for the mouths of all school children at government expense.—*Journal American Medical Association.*

ANTISCORBUTIC VITAMIN

Within the last few years research workers in nutrition have given much effort to work with different foods to determine their power to prevent or cure scurvy. This work has shown that foods vary greatly in their so-called antiscorbutic power, some being very potent in their influence on scurvy, and some being slow to draw conclusions as to its nature. However, evidence now seems to point strongly toward the presence of a third vitamin in those foods which are antiscorbutic, and many investigators think we are safe to add to the list a third one, which may be called the antiscorbutic vitamin, or "Water Soluble C."

The following table gives in very brief form the conclusions of some of the well known investigators regarding the presence of the antiscorbutic vitamin in various foods.

The survey was prepared by students in Miss Mary Henry's survey class in the School of Home Economics, Ithaca, N. Y. It is not a complete table, but it may be helpful and suggestive to those who are interested in the subject and yet who are unable to read the original articles.

ANTISCORBUTIC FOODS

FOOD	CONCLUSION	AUTHOR	JOURNAL	DATE
Milk—				
a. Fresh cow's	Antiscorbutic, but must be used in large quantities.	Chick, Hume and Skelton	Lancet	Jan. 5, 1918
b. Milk powder	Antiscorbutic power lost in preparation.	Hart, Stunback and Smith	Journal Biol. Chem., Vol. 38	June, 1919
c. Condensed (unsweetened)	Antiscorbutic power lost in preparation.	Hart, Stunback and Smith	Journal Biol. Chem., Vol. 38	June, 1919
d. Sterilized at 120°C. for 10 min.	Antiscorbutic power lost in preparation.	Hart, Stunback and Smith	Journal Biol. Chem., Vol. 38	June, 1919
e. Dried at 116°C. for few seconds	Antiscorbutic.	Hess and Unger (quoting Chick and Hume)	Journal Biol. Chem., Vol. 38	June, 1919
f. Aged—both raw and pasteurized	Antiscorbutic potency lessened until finally lost.	McCollum (quoting Hess, 1917)	Newer Knowledge of Nutrition	1919
Orange Juice—				
a. Fresh	Highly antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 35	Sept., 1918
b. Kept 3 months on ice	Half as efficient as fresh.	Hess and Unger	Journal Biol. Chem., Vol. 35	Sept., 1918
c. Heated under pressure	Value decreased.	Hess and Unger	Journal Biol. Chem., Vol. 35	Sept., 1918
d. Extracted with 95% alcohol	Antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 35	Sept., 1918
e. Artificial—prepared by formula of McCullum and Pitz	Not antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 35	Sept., 1918
f. Artificial	Antiscorbutic.	McCollum and Pitz		
Made alkaline—				
1. Fresh	Antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 38	June, 1919
2. 24 hrs. old	Value lost.	Hess and Unger	Journal Biol. Chem., Vol. 38	June, 1919
Orange Peel—				
a. Fresh	Highly antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 35	Sept., 1918
b. Dried	Somewhat antiscorbutic.	Hess and Unger (also Alfred Hess)	Journal Biol. Chem., Vol. 35	Sept., 1918
Lime Juice—				
a. Preserved	Not antiscorbutic.	Chick, Hume and Skelton	Lancet	Nov. 30, 1918
b. Crude	Slightly antiscorbutic.	Chick, Hume and Skelton	Lancet	Nov. 30, 1918
c. Fresh	Antiscorbutic.	Chick, Hume and Skelton	Lancet	Nov. 30, 1918
Lemon Juice	Highly antiscorbutic.	Chick, Hume and Skelton	Lancet	Nov. 30, 1918
Grape Juice	Slightly antiscorbutic	Chick and Rhodes	Lancet	Dec. 7, 1918
Prunes	Not antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 35	Sept., 1918
Carrots—				
a. Fresh	Antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 38	June, 1919
b. Young, boiled 20 minutes	Antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 38	June, 1919
c. Old, cooked longer	Slightly antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 38	June, 1919
d. Cooked 45 minutes	Not antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 38	June, 1919
e. Cooked in acidulated water	Not antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 38	June, 1919
f. Dried—young	Antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 38	June, 1919
g. Water in which carrots were cooked	Not antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 38	June, 1919
h. Raw carrot juice	Somewhat antiscorbutic.	Chick and Rhodes	Lancet, Vol. II.	Dec. 7, 1919
Raw swede juice	Highly antiscorbutic.	Chick and Rhodes	Lancet, Vol. II.	Dec. 7, 1919
Raw beet juice	Not antiscorbutic.	Chick and Rhodes	Lancet, Vol. II.	Dec. 7, 1919
Cabbage—				
a. Fresh	Highly antiscorbutic.	Delf and Skelton	Journal Biol. Chem., Eng. Vol. 12, No. 4	1918
b. Dried at 60° and stored two to three weeks at lab. temperature	Lost 93% efficiency.	Delf and Skelton	Journal Biol. Chem., Eng. Vol. 12, No. 4	1918
c. Stored 3 months at lab. tempererature	Slightly antiscorbutic.	Delf and Skelton	Journal Biol. Chem., Eng. Vol. 12, No. 4	1918
d. Plunged into boiling water before drying	Loss of antiscorbutic much decreased.	Delf and Skelton	Journal Biol. Chem., Eng. Vol. 12, No. 4	1918
e. Boiled and dried	Not antiscorbutic.	Givens and Cohen	Journal Biol. Chem.	Oct., 1918
f. Low dried, 38-40°C.	Very slightly antiscorbutic (merely delayed onset of disease).	Givens and Cohen	Journal Biol. Chem.	Oct., 1918
g. High dried, 75°C.	Slightly antiscorbutic but sufficiently to be curative.	Givens and Cohen	Journal Biol. Chem.	Oct., 1918
Oat kernel	Not antiscorbutic.	McCollum and Pitz	Journal Biol. Chem.	May, 1917
Germinated oats	Antiscorbutic.	Cohen and Mendel	Journal Biol. Chem.	Sept., 1918
Tomato—				
a. Canned, kept 1 year	Antiscorbutic.	Givens and Cohen	Journal Biol. Chem.	Feb., 1919
b. Boiled	Less antiscorbutic.	Givens and Cohen	Journal Biol. Chem.	Feb., 1919
c. Dried 35-40°C. for 35-52 hrs.	Delayed somewhat onset of disease (92 days).	Givens and Cohen	Journal Biol. Chem.	Feb., 1919
d. Dried 35-60°C. for 13-26 hrs.	A little more effective (110 days).	Givens and Cohen	Journal Biol. Chem.	Feb., 1919
e. Raw, fresh	Highly antiscorbutic.	Givens and Cohen	Journal Biol. Chem.	Feb., 1919
Egg, hard boiled	Not antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 35	Sept., 1918
Cod liver oil	Not antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 35	Sept., 1918
Liquid petroleum	Not antiscorbutic.	Hess and Unger	Journal Biol. Chem., Vol. 35	Sept., 1918
Fructose	Not antiscorbutic.	Harden and Zilva	Eng. Bio. Chem. Jour., Vol. 12	July 5, 1918
Lactose	Not antiscorbutic.	Harden and Zilva	Eng. Bio. Chem. Jour., Vol. 12	July 5, 1918
Bran	Not antiscorbutic.	Hess and Alfred	Am. Med. Assn. Jour., Vol. 71	Sept. 21, 1918
Germ of wheat	Not antiscorbutic.	Hess and Alfred	Am. Med. Assn. Jour., Vol. 71	Sept. 21, 1918
Brewers' yeast	Not antiscorbutic.	Hess and Alfred	Am. Med. Assn. Jour., Vol. 71	Sept. 21, 1918
Banana	Poor antiscorbutic.	Hess and Alfred	Am. Med. Assn. Jour., Vol. 71	Sept. 21, 1918
Dehydrated fruits and vegetables	Poor antiscorbutic.	Hess and Alfred	Am. Med. Assn. Jour., Vol. 71	Sept. 21, 1918

NEWS ITEMS

Miss Cecile Haines has accepted a position with Mrs. O'Dea, in the dietary department at Johns Hopkins Hospital. Miss Haines finished the student dietitian training with Mrs. O'Dea early in the year and has since been at her home in Sayre, Pa., on account of illness in the family.

Miss Laura Bowles severed her connection with John Proctor Hospital, Peoria, Ill., and is spending the summer on the Pacific Coast. Miss Bowles has been dietitian at John Proctor Hospital for some time.

Miss Lute Trout has given up her work at Robert Long Hospital, Indianapolis, in order to take some further work in dietotherapy. Miss Trout took student dietitian training at this hospital and remained as dietitian for two years.

Miss Sackman has gone to the Chicago Beach Hotel as assistant to Miss Ackerson. Miss Sackman was formerly at Michael Reese Hospital as Miss Chambers' assistant.

Miss Louise Keegan, formerly dietitian at Ithaca City Hospital, is at her home in Crawfordsville, Ind., for a few months' rest.

The Philadelphia dietitians have a very live organization and have accomplished some worth-while things during the year. In addition to the things they have done of local value, they have made the following contributions:

Visiting Nurse Society	$ 24.24
Child Federation	24.24
Nutrition Clinic of Children's Hospital	24.24
Total from Club Treasury	$ 72.72
Special contribution by members to European Relief Council	$ 50.00
Total	$122.72

Best of all, they have sent promptly, interesting reports of their meeting for publication in this department, so that other dietitians may receive benefit and inspiration therefrom.

Report of the Dietitians' Section of the Home Economics Association of Philadelphia for the Year Ending May, 1921

During the year eight meetings have been held, as follows:

I. On September 30, at the Pennsylvania Hospital, Eighth and Spruce Streets, a report of the Lake Placid Conference was given by Miss Emma Smedley, director of School Lunches of Philadelphia, and Miss Harriet Mancill.

II. The October meeting was arranged by the dietitians' section of the Home Economics Association. This was a political meeting held on the eve of woman's debut as a voter, and, therefore, felt to be timely. By invitation of Miss Edith Baer, we met at College Hall, University of Pennsylvania, where some of the questions before the country, both state and Federal, were discussed by John Henry Gibbon, Esq., attorney for the Emergency Fleet Corporation, and Miss Jessie Evans, instructor of history and civics at the William Penn High School for Girls.

III. The meeting of November 18 was held at Pennsylvania Hospital, Eighth and Spruce Streets. Subject: A report of the Convention of the American Dietetic Association held at the Hotel McAlpin, New York City, the latter part of October. Eight members of the section contributed to the enthusiasm of this meeting, bringing back notes on papers and plans of the Association.

IV. Our next meeting, which was arranged for January 27, was held at the Pennsylvania Hospital for Nervous and Mental Diseases at Forty-ninth and Market Streets. Subject: Points to be emphasized in teaching dietetics in training schools for nurses. Speakers: Miss Roberta M. West, R.N., secretary-treasurer, Pennsylvania State Board of Examiners for Registration of Nurses, and Miss Sara M. Murray, R.N., educational director of Training School for Nurses (state of Pennsylvania).

V. The February meeting, held at the Pennsylvania Hospital, at Eighth and Spruce Streets, was varied by a discussion of their individual problems by members of the section. A social time, with refreshments, added to a pleasant and profitable afternoon.

VI. On March 14, the dietitians' section enjoyed the hospitality of the Philadelphia League of Nursing Education at the Presbyterian Hospital. Subject: Round Table on "Teaching Dietetics."

VII. On March 31, our monthly meeting was held with the Home Economics Association at the Widener Library. The program was arranged by the dietitians' section, as follows: on the Work of the Board of Public Health under Dr. C. Lincoln Furbuch: (1) Nutrition Problems, Miss A. L. DePlanter, nutrition expert with Child Federation, Philadelphia; (2) Occupational Therapy in General Medical Work, Miss Ida F. Sands, director of occupational therapy at Philadelphia General Hospital; (3) For Mental Patients, Miss Mabel M. Bond, director of occupational therapy, Philadelphia Hospital for Mental and Nervous Diseases.

VIII. On April 27, the annual meeting was held at the Philadelphia General Hospital. Previous to the business meeting, Miss Claribel McCrae demonstrated before the section, methods of teaching dietetics to student nurses. Miss McCrae's class of twenty senior nurses prepared diets for typhoid and diabetic patients according to printed directions, previously worked out in class in theory. The difference between good and poor diets was pointed out, with the reason, at the conclusion of the lesson. The food was served on trays and later carried to the patients. At the business meeting the following officers were elected for the years of 1921-22: chairman, Miss Claribel McCrae, Philadelphia General Hospital, Thirty-fourth and Pine Streets, Philadelphia; treasurer, Miss Eunice Bowser, Kensington Hospital for Women, 136 Diamond Street, Philadelphia; secretary, Mrs. J. M. Fuller, Pennsylvania Hospital for Mental and Nervous Diseases, Forty-ninth and Market Streets, Philadelphia; Mrs. G. S. Hubbard, Ellis College, Chestnut Hill, Pa.; Miss Florence L. Shippee, Presbyterian Hospital, Thirty-ninth and Filbert Streets, Philadelphia. At this meeting a committee was appointed to consult with the officers of the Home Economics Association as well as with the American Dietetic Association, regarding the possibility of being released from the Home Economics Association as a section, and making such affiliation with the American Dietetic Association at the end of another year. The committee is composed of Miss Helen E. Gilson, chairman, Miss Emma Smedley, and Miss Ellen M. Gladwin. To end the club year, a banquet was held on Friday, May 13. It was arranged by the following committee: Miss Alice Hall, chairman, Miss Eunice Bowser, and Miss Euphemia Cameron.

Miss Laura M. Brant, of the City Hospital, Columbus, Ohio, in an address to the training school for nurses says that the days for long hours for young nurses are over. All the young nurses are limited to an eight-hour day and the first-year girls have all day Sunday for themselves. This has been done in an effort to make the nursing profession more attractive.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

THE MARKET'S TREND

BY CHARLES L. HAYS, CHICAGO, ILL.

PROGRESS toward business revival is so slow as to be hardly noticeable, and the chief consolation for this state of affairs lies in the fact that the foundations are constantly becoming more safe and sound. Liquidation, the duration of which bankers hesitate to define, is going ahead, but there is still a long distance to go, and the events of the last month have only emphasized the need of patience in awaiting a return of prosperity. Money is easier in the east, but there is little change in the central states, notwithstanding the reduction of the federal reserve bank's rediscount rate from 7 to 6 per cent and a decline in the rate on commercial paper from 8 per cent to a range of 6¾ to 7¼ per cent. Many of the largest Chicago banks have reduced materially their loans from the reserve bank, but in the agricultural regions conditions are still close, and there is not likely to be much relief until after the marketing of the year's crops.

An active and strong investment market in May has given place to dullness and sated demand, following an oversupply of new issues of large size. One of the best investment opportunities of the year was afforded by the offering of $230,000,000 joint 6½ per cent bonds of the Great Northern and Northern Pacific railroads, secured by deposit of 97 per cent of the $170,000,000 stock of the Chicago, Burlington & Quincy road and convertible into long term bonds of the Northern Pacific bearing 6 per cent or the Great Northern bearing 7 per cent. This issue sold well, but the $100,000,000 of French government 7½ per cent bonds, a little later, was not so quickly taken and served to take the edge off the market. An exceptional short term investment is presented in the offering by the treasury department this month of $500,000,000 one and three-year notes, the latter bearing 5¾ per cent interest and non-callable before maturity. There has also been an outpouring in June of state bonds for public improvements and soldiers' bonuses. New York led with $41,800,000 five per cents, New Jersey and Michigan making up the rest. The treasury notes have been bought freely by institutions and individuals with funds temporarily idle.

Labor More Efficient

There has been a considerable increase in labor efficiency, and much shifting with this end in view, made possible by the large numbers of unemployed. The ranks of the idle have decreased slightly recently because of the labor needs of the country and an increase of operations in many automobile plants, but there has been little change for the better in industrial activity in the last month. Manufacturing is marking time, and in the steel mills there has been further curtailment of operations.

Building has been resumed in Chicago, with the ending of the labor deadlock, giving employment to 20,000 or more idle. Materials have undergone no further decline, and are not expected to, as the demand is so limited that reductions would not increase the volume of business much, and dealers know that with the labor obstruction removed the call for materials will be greater than they can supply regardless of prices.

Textiles Steadier

Textile markets are steadier, and merchants are showing more disposition to cover their needs for fall. Early this month wholesalers and jobbers held extensive clearance sales in which attractive price markings were a feature, the intention being to break as far as possible the hand-to-mouth buying practice which retailers have followed for months. The effort was moderately successful and a satisfactory turnover was effected. Domestics, ginghams, percales and knitwear led the offerings and also the sales. Shoes are moving more freely and there has been an advance of 5 or 6c a pound in hides as a result of greater manufacturing demand for leather. Household furnishings are still in slow demand and without material change in price. Furniture shows more resistance to the process of readjustment than almost any other line, and the reluctance of buyers to take hold is a natural result.

Food Prices Irregular

Food prices have moved irregularly during the last month, with the trend generally lower. Flour is about $1 a barrel higher because of the advance in the price of wheat, but other cereals are lower, especially when purchases are made in bulk. Package goods are still much higher as compared with the raw materials than in normal times. With raw sugar at 4.25c, the lowest price in four years, there has been a slight reduction in the wholesale price of refined, which is now around 6.30c. Meats and lard are a little higher, poultry 5c lower, butter 1c higher and potatoes unchanged at 70 to 90c. There is an abundance of green foods in the markets, but except for those who can buy at first hands or with at most one rehandling prices are not especially low. The same is true of fruits, there being a marked difference between supplies of either kind grown near home and those that have to bear the high freight rates and the heavy cost

of distribution. Canned goods are steady and not in overabundant supply. Some of the new pack is coming in, but this increase in supplies is not likely to weaken the markets as much as in normal years, for in most packing centers there has been a material reduction of plant activity because of the large carry-over and the losses sustained in the readjustment of prices that has occurred in the last six months.

The fine crop prospects of the year furnish the greatest element of strength in the business situation and also the strongest hope for a continuation of the downward course of foods.

The yield of winter wheat, according to the government estimate, will be 578,000,000 bu. and of spring wheat 251,000,000 bu., a total of 829,000,000 bu., which is 42,000,000 bu. more than the crop of last year and only 2,000,000 bu. less than the ten-year average. The condition of the growing grain is exceptionally good. On the basis of these figures there will be enough for domestic needs and an exportable surplus of 200,000,000 bu. Should present prospects for oats be maintained until harvest there will be a record crop, exceeding last year's total of 1,526,000,000 bu. The acreage, 44,829,000, is the largest ever planted to this grain. Conditions are favorable for corn and potatoes, and the low price of grains have encouraged the feeding of cattle and hogs on a larger scale, which should increase meat supplies.

Crude rubber has had a further decline of 3c to 13½c, failure of the promised revival of the automobile business, which began about two months ago but was not maintained, being the principal reason. While the low price is slow in making itself felt in the quotations for miscellaneous manufactures it undoubtedly will exert a strong influence eventually in bringing these down to something like pre-war levels.

Increased demand for paint materials has strengthened these markets and linseed oil is up to 80c, warehouse delivery, while white lead and kindred supplies also show a firm tendency.

The market for drugs and chemicals was strengthened considerably with the approach of the passage of the emergency tariff bill, but weakened when the period of its application was cut from six to three months, then steadied again when Congress gave evidence of proceeding expeditiously with the consideration of the permanent customs measure. Cocaine hydrochloride reduced $1.00 by the makers to the basis of $7.00 an ounce for small crystals and $7.25 for large crystals, granular and powder. Hard mercurials also are lower, the new wholesale base for calomel being eighty-two cents a pound. Formaldehyde is steady at fourteen to fifteen cents a pound. Quinin is easier, but with no quotable change in prices. Alcohol is held at $4.90 to $5.00 a gallon. Ether at twenty-four to twenty-six cents is unchanged.

REDUCING INSTITUTIONAL FOOD COSTS*

By MARGARET HOOKER, Domestic Science Instructor, State School for Girls, Adrian, Mich.

BUTTER making is one of the four leading food industries of this country. Butter, an ever present food, is one of the first to be criticized. Most persons have a very keen taste for a certain butter flavor, and oftentimes judge an institution by its selection and use of this commodity.

The best way to buy butter now is in the pound print, this can be depended upon to be sound, of even flavor, and rarely rancid. Buy direct from the factory or creamery, if possible, and, as butter is an all year round necessity, contract for it. The contract will probably be subject to fluctuating prices, sometimes the manufacturer will take a risk and agree to sell his goods at a few cents below normal, in consideration of the fact that he has a steady customer.

In selecting butter the buyer is particular first about the flavor. Other points which he looks for are good body qualities, coloring, and the amount of salt used. Sometimes "renovated" or "processed butter" is sold right along with original butter. In some states this is prohibited. Butter which has become rancid or has an undesirable flavor is made over again by a certain process. This should be sold cheaper; it is very good for cooking but not a first grade table butter. It may be distinguished from original butter by melting, if it foams with little noise it is original, if it sputters noisily it is processed butter.

Tub butter is usually a few cents cheaper than the brick, but is not considered by many the most desirable.

If butter is to be bought for storage, the best time to do this is from May until August. During May and June the butter scarcely ever has to be artificially colored. Use utmost care in choosing the butter. It should be pasteurized, which will insure it against pathogenetic bacteria and will also keep it at a more uniform flavor. Store the butter in a room about 50 degrees Fahrenheit, keeping it dry and separate from other foods, as it readily absorbs odors. It will keep, under these conditions, from six to eight months, or perhaps a year. Do not try to keep unsalted butter.

Butter holds a very important place in the diet, it is highly nutritious, however, it is not so much so when cooked, as it decomposes at a rather low temperature. It assists in digesting bread, upon which it is most commonly used. Butter being about 85 per cent fat, is of course very high in calories. It contains the growth promoting vitamin known as "fat soluble A." Butter substitutes such as oleo and the nut butters are lacking in this element so cannot take the place of real butter. A smaller quantity of substitute than of butter, may be used in cooking, as butter contains more water.

Butter Substitutes

Oleomargarine was the first butter substitute manufactured. It was made in France at a time of necessity, during the Revolution. It is still made and used extensively in Europe and in this country. The name "oleomargarine" can cover nearly all the butter substitutes that are on the market, although they are sold under different trade names, for their composition is practically the same. In some there is a small amount of butter, but most generally it is oleo, which is a medium grade animal fat. Sometimes the fat is from nuts, cotton-seed, or vegetables. The slight butter flavor which may be present, is due to the fact that it was churned in milk.

The selection of oleomargarine is not very difficult, as most persons have their opinion as to which one "tastes

*This is the third of a series of articles by Miss Hooker, on "Reducing Institutional Food Costs." The first two appeared in the April and May issues of The Modern Hospital.

the most like butter." Its composition and coloring are closely guarded by Federal control. The revenue is so high on artificially colored oleomargarine that it is always sold colorless, oftentimes accompanied by the coloring. The fuel value of oleomargarine is excellent, and when fresh and sweet it is superior to inferior grades of butter.

Eggs

Eggs, in particular, are a commodity which have been found to be more profitable to buy in their season of plenty. March is generally the month of lowest prices. Eggs should be stored between the months of March and June. The raising of poultry is a science which is bettering itself every year. With good breeding comes the classification of birds which are raised for meat and those for eggs. The poultryman who makes a specialty of eggs is the one to buy from, and not the one who simply has the eggs on hand. Eggs for sale are divided into three classes, fresh, held, and storage. A strictly fresh egg is one which is not over twenty-four hours old, after this the egg starts to deteriorate on account of the porosity of the shell, which admits air and other foreign substances. Held eggs are those which the poultryman holds, waiting for a rise in prices. Storage eggs are good, now that cold storage methods have been worked out successfully.

Some persons are also very particular about the color of the shell. A brown shelled egg is preferred in New England and brings the best prices, while in New York the white shelled egg is preferred. The Western states have no preference, as the contents and food value are the same.

In selecting eggs, look for rough shells. They should give a clear metallic sound when rubbed or tapped together. The egg should not make any sound when shaken. Be sure they have been candled unless they are positively known to be strictly fresh. Infertile eggs will always keep the best. Oftentimes cold storage eggs are superior to "fresh" eggs, as they have had the benefits of refrigeration.

In keeping a large quantity of eggs such as would be needed in an institution, cold storage is the best method. Water glass solution is best for household use. There are many other ways, such as packing in table salt, sawdust, bran, oats, salt solution, slaked lime, vaseline, paraffin, or patented preparations. In all of these methods the principle is the same; that is to exclude the air. Good results have been obtained by sterilizing eggs before placing them in cold storage. It is done by coating them with oil at a high temperature, afterwards removing it with carbon tetrachloride. The temperature in which eggs should be stored is from 29 to 32 degrees Fahrenheit. The room should be dry and free from strong odors. Eggs will keep in this way from eight to ten months.

One very good reason for the popularity of eggs is their ease of preparation. They are a complete food, but should not be used as the only source of food. Eggs are very easily digested; hard cooked eggs are absorbed the same as soft, but take a longer time. Raw eggs should not be served unless it is necessary, as they are very distasteful to most persons and this psychological effect will impair their digestion.

Care must be taken not to cook eggs in too high a temperature, as this toughens the protein in the white, making it very undesirable. The way eggs are beaten makes quite a difference in the final results of cookery. Egg whites should be beaten on a platter or plate, so that the air can be easily incorporated. Unless otherwise directed, the yolks ought to be beaten until thick and lemon colored. There are countless delicious ways of serving eggs. They are the best meat substitute and preferred by many to meat. Clean egg shells are excellent for clearing coffee and soup stock.

The sale of egg substitutes, which are generally falsely represented, has been forbidden. The only way they resemble eggs is in their thickening powers. Sometimes eggs are frozen or dried. These have been used successfully, but not to any great extent.

Cheese

Cheese, up until recent years, has been chiefly a condimental food. It now occupies a rather important place in the daily dietary, forming sometimes the main dish of a meal. Purchase cheese from a local creamery if possible; this will probably eventually save on the cost. There are two general classes of cheese, the hard and the soft. Some of the hard cheeses are Cheddar or American, Edam, Parmesan, and Roquefort. The soft are Brie, Limburg, Neufchâtel, and cottage cheese.

When choosing cheese, some of the qualifying points are its flavor, uniform color, and its body appearance. Cheese is usually preferred when of a creamy consistency, the flavor depends upon the bacteria culture which has been used. Cheese should be kept in a cool place and well covered, a glass case is best.

American cheese is the most common and the cheapest cheese to buy, so it will be the one chiefly considered here. Some of the best uses for cheese are in combination with carbohydrate foods, as rice, macaroni, potatoes, and the always popular cheese soufflé or rarebit. Leftover and dried bits of cheese may be grated and served sprinkled over a salad or vegetables.

The cost of cheese is about the same as meat; there is more protein and fat contained, however, with practically no waste. Cheese is a concentrated form of milk. One gallon of milk will make one pound of cheese. Cheese is sometimes very indigestible, but if eaten in the proper combinations and not eaten between meals, alone, it shows no ill effects.

Roquefort cheese is much favored in salad dressings. The Italians think spaghetti incomplete without Parmesan cheese. Cottage cheese is very economical and wholesome, there are also countless ways in which it may be served either cooked or uncooked. It is made very simply from skimmed milk.

Milk

Milk is the one food that it is necessary to buy daily. Naturally, it will be bought from the best local dealer. As milk is the best medium in which bacteria grows, it is absolutely necessary to insist upon sanitary handling. No time need be spent on selection of this food, but it should be spent upon investigating the conditions under which it has been handled before reaching you. Very often, with the changing seasons, the composition of milk varies. If the change is too radical and the fat content reduced too much, send it to the nearest government experiment station for examination. In this way your dealer will know that you are guarding against adulterations.

It is needless to state here the food value of milk. It is an absolute necessity in the daily dietary. Its use should never be cut down, even if the price does seem to rise very high, it is never too high in proportion to other foods. If a separator is in use in your institution, be sure that good use is made of all skim milk. Statistics show that 37 per cent of the milk produced annually in the United States is skimmed, and that nearly all of this skimmed milk is wasted.

Evaporated milk is pure, wholesome milk with part of the water removed. During the process of evaporation it has been found that little or none of the food value has been destroyed. If it is hard to obtain good, clean, fresh milk in your locality it would be wise to lay in a supply of evaporated milk. Condensed milk is about the same as evaporated milk except that it has sugar added to it. The sugar acts as a preservative, and also makes it an economical constituent when used in cookery.

There are also dried or powdered milks which are now on the market. These are not used extensively, although experiments for their use have been found successful.

CABLE INVENTS IRRIGATING TABLE

While in charge of a hospital at Newport News, Virginia, devoted exclusively to the treatment of venereal diseases in women, Dr. E. E. Cable of Portland, Oregon, perfected a table for this use which has many advantages over other methods employed.

The purpose of the equipment is to facilitate administering a douche, particularly in institutions where a large number of women are confined. It is claimed that a single nurse in a hospital accommodating fifty patients was able to give each patient two five gallon douches a day.

With this equipment, also, it is possible to give a douche of any desired temperature, medicated with any drug the operator may select, and in any quantity required, this being limited only by the size of the tanks.

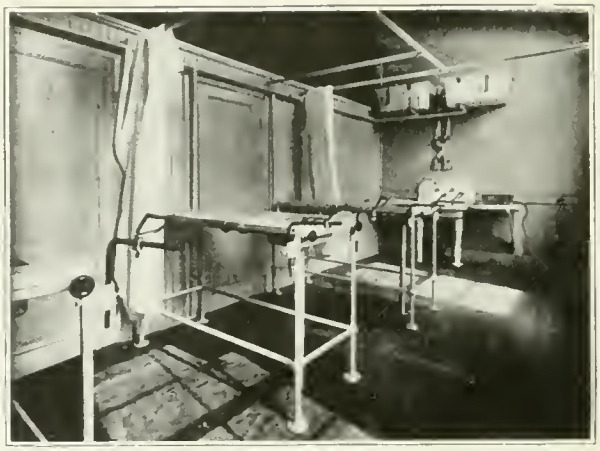
It will be noted that only a small space is required to install table and equipment.

It will be observed that the tanks are placed high enough to allow the patients to enter the room between the tables, thus avoiding interference with doctor or nurse.

The equipment comprises a treatment table, water supply tanks for tempered water with the necessary control valves for filling the tanks from the ordinary house supply of hot and cold water, all so arranged that the temperature of the water can readily be noted from a thermometer mounted on the tank.

Each tank is provided with a pipe leading to the drain basis, and empties into it through a common "T" connection with a short pipe passing through the drainage basin having a hose nipple for the rubber tube connection. Each pipe is fitted with a valve located at the foot of the table through which the contents of either tank may be released into the drainage basin. To provide for safety the tanks are fitted with an overflow which eliminates all danger from that source.

A picture of the table installed in the U. S. Public Health Service Clinic, located in the Skin and Cancer Hospital, Second Avenue and East 19th Street, New York City.



The above photograph shows three tables installed in the treatment room in the Riverside Hospital on North Brother Island, New York.

The table is made entirely of steel, mounted on non-corrosive floor flanges which permit attaching securely to the floor.

THE TIME TO REDUCE BREAKAGES

Hospital buyers may be surprised when told that the time to reduce the breakage of china and glassware to a considerable degree is at the time of purchase. This does not refer to the quality of ware that is purchased as much as to the design.

It is but natural that kitchen help in removing dishes, in placing them in the dish washer, or in returning them to the pantry will stack glassware and china of certain designs which it is virtually impossible to stack compactly and securely. As a result a great number of pieces are broken, and this loss might have been avoided by exercising greater care in the selection of designs. Almost all large manufacturers and dealers in china and glassware have shapes which are designed to avoid unnecessary breakage in stacking.

It has been found that much of the breakage in hospitals is caused in actual food serving, in carrying the food to and from the patient. Dishes are piled too high on trays or on the soiled dish truck, while collisions and missteps precipitate many to the floor. Warming ovens are also the cause of considerable breakage. The dishes are piled carelessly in these heaters and are removed in haste.

The greatest breakage is found in cups. This is partly due to their greater use, and partly to their design.

The breakage of water glasses in hospitals amounts to a considerable sum. It has been found that this breakage is caused by deficient shelf space, small crowded pantries, and the reckless jumbling of glasses and heavy dishes on the same tray. In almost all institutions the glass pantries are small and frequently misplaced. The pantry should have roomy shelves, upon which the trays of soiled glasses may be kept until there is room to handle them. With glasses as with china, faulty design causes much breakage. Glasses are stacked, become jammed or topple over, adding to the monthly expense bill.

"Publicity for hospitals and homes should not be spasmodic. A persistent campaign of publicity such as is carried on by the average successful business house would be as effective and is as essential for institutions of this character, as for them."—RALPH WELLES KEELER.

AUTOMATIC SPRINKLER INSTALLATION FOR HOSPITALS

By WILLIAM DENSMORE BROWN, F.P.E., Boston, Mass.

HUNDREDS of millions of dollars are required each year for the care of more than a million sick, crippled, aged, blind, and otherwise defective persons. Intelligent and devoted service on the part of managements and staff constitutes the greatest example of Christian service that is found in our modern civilization.

The greatest impediment to this scientific system is the fire menace. Hospital and asylum fires are the most dangerous. The inmates are helpless and the attendants too few for this unforeseen occurrence.

The majority of hospitals have wooden floors, hallways, and stairs. Their basements, attics, kitchens, laundries, and often power plants, contain combustible material, and very often are fire hazards requiring special precautions.

The constant repetition of serious fires in such properties has brought boards of trustees and other responsible persons to the realization that the human element is not dependable for this exigency. These persons have adopted automatic sprinklers as scientific fire protection in safeguarding life and property. Insurance experts, realizing the value of this protection, have encouraged it by reducing insurance rates.

Automatic Sprinklers

Automatic sprinklers are not incomprehensible devices used in a mysterious manner for extinguishing fire, but on the contrary they are a proven and practical invention successfully operating on the facts that all fires will generate heat, and that water, when supplied in sufficient volume, will put out fire.

In general, the modern sprinkler head consists of a one-half inch orifice, the lower portion connected to sprinkler pipe and "stopped" on top by a disc of some non-corrosive substance—glass, silver, or porcelain is now being used. A few inches from this disc is a deflector or "splash plate." The stopper or disc is secured in place by a series of metal pieces held together by fusible solder, and so arranged that they form a strut or brace between stopper and deflector.

A rise in temperature causes the solder to melt; the struts or braces then spring apart and release the stopper or disc, the water escaping strikes the deflector, which breaks it into a shower that effectively extinguishes the fire.

THE START OF THE FIRE
A view of an actual fire started in a basement of a schoolhouse during school session.

Supplies

Sprinkler heads are connected to a series of small pipes located close to or concealed in ceilings. These pipes are supplied from larger pipes called mains, running nearly horizontal. The mains are in turn supplied by a riser, which is a vertical pipe extending from the bottom to the top of the building, usually fed from one or more of the following sources: elevated gravity tank or air-pressure tank, reservoir pressure from either public or private mains, underwriters' fire pump. In considering supplies for sprinklers, pressure is more important than volume. Experience has shown that one sprinkler, operating under heavy pressure, will extinguish a fire much more promptly and effectively than when water pressure is weak, even though the supply may be ample.

Operation

The sprinklers located close to the ceiling are in an advantageous place to be affected by the heated air, which naturally ascends. The fusible solder, which can be made to suit any particular needs, under normal conditions melts at temperatures ranging from 155 degrees to 160 degrees Fahrenheit. A slight rise in temperature causes the sprinkler to open up, bringing down on the fire a drenching rain, which fully covers an area of eighty to one hundred square feet. The small blaze is extinguished before it can become a fire of larger proportions.

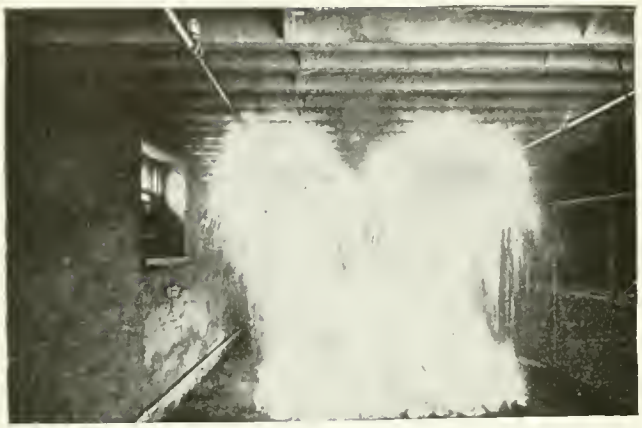
In general, automatic sprinklers might be described as mechanical watchmen, their duty being to extinguish any and all fires. They have the advantage over the human watchman, inasmuch as they do not go to sleep, and in case of an emergency they do not get excited or are not blinded by smoke.

Alarms

Sounding the alarm of fire is the first consideration after discovery, as it is impossible for the person to judge whether he is going to control the fire or not, and if he does not, and spends valuable time in the futile attempt, it will probably be too late when trained assistance arrives.

There should be an alarm valve attached at the base of the supply pipe for the purpose of giving notice that a fire is in progress, while the sprinklers are extinguishing the fire. This valve is so arranged that an alarm will be given when the opening of a sprinkler causes a flow of water through riser and valve. In general, an alarm valve is a check valve with a weighted clapper. Under normal conditions the pressure throughout the sprinkler system will be the same as that on the supply side of the alarm valve, the weight of the clapper keeping it closed.

In case a sprinkler head opens, the pressure on the system side of the check valve is immediately relieved and the continued pressure on the supply side will open the clapper of the valve. The opening of this clapper



SPRINKLERS OPERATING

Showing the sprinklers in operation. Water is distributed over the source of the fire, the remainder of the building not being affected. When this picture was taken the automatic alarm consisting of a gong located on the outside of the building and an electric bell in the watchman's headquarters, were operating. The occupants, drilled for the occasion, were marching out to safety.

permits a flow of water through a small pipe which operates a mechanical gong on the outside of the building. At the same time an electric device, regulated by the flow of water or action of a clapper, operates a gong, which is usually located in the watchman's headquarters.

Dry Pipe Valves

Buildings that have no heating facilities, or such portions of a building where water in sprinkler pipes would freeze should be equipped with a so-called "dry pipe" system.

The piping in the area exposed to freezing temperature is filled with compressed air, and between the air-filled pipes and the water supply is located a dry valve, that is, a valve in which air pressure on one side balances the water pressure on the other side. When a sprinkler opens, the air escapes and the pressure of water opens the dry pipe valve and admits water to the sprinkler system. The water flowing through a dry pipe valve operates the mechanical gong and electric bell.

Locations

Sprinklers should be placed throughout the premises, including basement, lofts, under stairs, inside elevator wells, inside small enclosures and all obstructions that would shelter a fire from the sprinkler spray.

In some cases the appropriation is not large enough to cover a complete automatic sprinkler system, in this event a modified sprinkler system may be designed, the chief feature being the omission of sprinklers where the fire hazard is negligible.

Automatic sprinklers, when installed as a partial equipment, have rendered the great majority of fires harmless to life and of small damage to property. In all events sprinklers have accomplished their duty, namely: retarding the spread of fire, and protecting exits, thus allowing the occupants an opportunity to escape without harm. There is also a moral effect of the presence of water in stairways and exits, in case of fire, which has a tendency to calm excitable persons and has been known to avert a panic.

All basements, attics, storerooms, attachés' sleeping quarters, laundries, kitchens, tops of elevators, light and ventilating shafts, hallways, exits, and retiring rooms, including toilets, should be protected.

The life of a sprinkler system as far as the piping, valves, and sprinkler heads are concerned, and when given proper attention, is probably as long as the life of the building.

The greatest hindrance to an efficient operation of a sprinkler system is the human element. No better method of conveying general information in regard to this statement can be followed than by referring to a summary of fires where sprinkler control was not as effectual as is usually the case.

Each water supply should be provided with a gate valve located where readily accessible, and for the purpose of controlling water in the sprinkler system. Twenty-seven per cent of this impaired efficiency is due to these control valves being closed, depriving the sprinkler system of water.

All control valves should be secured open by devices such as padlocks or riveted leather strap, and left in care of some responsible person.

Defective water supplies represent 10 per cent of this impaired efficiency.

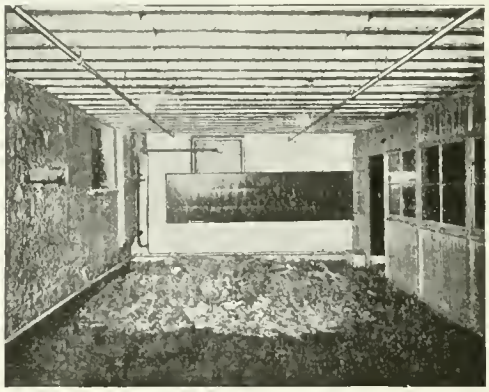
All sprinkler systems should have at least twenty-five pounds static pressure on the top line of sprinklers and should have a capacity, in the case of average hospitals, of at least 20,000 gallons.

Generally defective equipment and fires spreading from unsprinkled portions constitute 22.9 per cent of impaired efficiency. There are places where acid or alkali fumes may attack the metals which are employed in all types of sprinkler heads. Various methods have been tried for preventing this corrosion, the result being that several prominent sprinkler companies are using, where necessary, wax coated heads, glass cups, and other devices.

It is suggested, where sprinkler systems have been installed for a period of ten years or more and where exposed to corrosive influences, that one or two sprinklers be removed from each room and sent to the nearest underwriters' laboratory for examination.

In freezing weather care should be taken to see that water in sprinkler pipes will not freeze. This condition has caused 3 per cent of impaired efficiency, and numerous small leaks have been traced to this source.

Yet, in spite of the carelessness of the human element, the remarkable results obtained by automatic sprinklers in the extinguishment of fires is best shown by referring to the twenty-two years record of the National Fire Protection Association, which includes 20,097 fires in sprinklered plants, where heat was sufficient to operate the sprinklers. This record shows that automatic sprinklers operated successfully in 95.6 per cent of all fires.



FIRE EXTINGUISHED

A view of the remains of what might have been a serious fire. A fire similar to one illustrated above caused the death of one hundred and seventy-three children and two teachers in the memorable Collingwood School, Cleveland, Ohio.

Occupational Therapy and Rehabilitation

Conducted by HERBERT J. HALL, M.D., President, National Society for the Promotion of Occupational Therapy, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

NATIONAL SOCIETY AND STATE SOCIETIES

OCCUPATIONAL therapy has developed normally, first the small beginnings, the individual workers scattered about the country, men and women who saw the light though they could not realize what was coming, then the war service with its tremendous call for practical workers, now the really constructive period. The national society, organized in 1917, was the first in the field, and this group has accomplished a great work. It has held occupational therapy together, it has helped to shape the general policy, it has accomplished through its annual meetings a cooperation which would have been impossible without such an organization. But this parent society, with its infrequent meetings, could not completely serve the purposes of progress. Therefore, we now have the state societies, which will bring about a far more effective personal contact and cooperation among occupational therapy workers and the allied groups in social service.

It is well for us at this time, in the early days of the state societies, to consider what should be the relationship of the local organization with the national body. If we do not think it out now there may be a good deal of unnecessary lost effort, and perhaps misunderstandings and jealousies.

The tendency may be for the state society to become all-sufficient, for the members to give all their allegiance at home and so miss the splendid opportunity for larger growth which exists in national affiliations. We shall be wise if we think, from the first, in national as well as in state terms.

Theoretically, the state organizations should be in effect branches of the national society, supporting that body by money contributions as well as in loyal service, but practically the situation seems to be working out somewhat after the fashion of the medical societies. The American Medical Association has an independent existence, it has no local authority, and it is made up of members who voluntarily join while they retain their membership in the state societies. This is perhaps, after all, the best arrangement. But it should be a matter of pride for every member of a local or state occupational therapy society to belong also to the national body. There will be then a vital and practical connection, made closer, if possible, through a house of delegates, the members of which should be appointed from the states and who should meet with the board of managers of the national society at least once a year, preferably oftener.

It is the writer's intention, as president of the national society, to invite the existing state organizations to send delegates to the next annual meeting in Baltimore. A conference of this sort cannot fail to be of great usefulness. The states will in this way send reports of their progress and they will in return receive direct news of all that is going on in the national field. It is a simple and natural arrangement. The board of management of the national society will be properly advised by the state societies. There need be no clashing of authority, there need be, as a matter of fact, no actual authority, but instead a friendly cooperation and understanding, an interchange of ideas which will save us from provincialism, and which will splendidly serve the general cause.

The national society meetings cannot fail to be of the greatest service to individual workers. The advantage of reunion is enough, but the papers which are read, and the round table conferences on a national scale should be of sufficient value to repay many times over the aide or director who makes the sacrifice of a long journey.

We are not serving two masters when we are loyal to the state and the national societies, for they are in effect one and the same. Their ends and aims are alike, save that the national society serves to hold the state societies together, and so to increase their general usefulness.

MAKING PLANS FOR NATIONAL CONFERENCE

It is time to begin making plans for attendance at the national conference of the N. S. P. O. T. which will be held in Baltimore, October 20, 21, and 22, 1921. All hospitals where aides are in service should be willing to grant leave of absence for this meeting. Here will come together experts in rehabilitation from all over the country. There will be formal addresses and round table conferences of the utmost value. Best of all is the opportunity for renewal of old acquaintances, and the interchange of personal experiences.

Doubtless there will be representatives present from all the occupational therapy schools, and from each of the new state societies. Occupational therapy is a national as well as a local institution. It is through these great conferences that we must develop the broader scope and secure for our principle the sound and rapid development which it deserves.

The headquarters of the meeting will be at the Southern Hotel, and the rates will be as low as is consistent with good service. Further details will be given as the time approaches.

"The primary purpose of occupation may be said to be to divert the patient's mind from unpleasant subjects, as in the case of one depressed."—William Rush Dunton, Jr.

MILWAUKEE-DOWNER COLLEGE GIVES O. T. COURSE

By CHARLOTTE R. PARTRIDGE, Department of Occupational Therapy, Milwaukee-Downer College, Milwaukee, Wis.

IN SEPTEMBER, 1918, Milwaukee-Downer College instituted a course in occupational therapy as an emergency war measure. At that time the training was eighteen weeks of intensive work in design and crafts, and lectures by prominent physicians and specialists. The need for occupational therapy, however, did not end with the war. At present there is a growing demand for well-trained workers in state and private institutions and, to quote a famous specialist, "Occupational therapy work is especially adapted for refined and intelligent young women." Therefore, Milwaukee-Downer College deemed it too valuable a course to be omitted in this, a women's college.

The Milwaukee-Downer course in occupational therapy is open to mature women. It is planned as a postgraduate course, though craft workers, teachers, and graduate nurses who are not college graduates but who have had practical experience of the right kind have taken the work successfully. Freely speaking, the essentials are a pleasing, cheerful personality, a refined, well-groomed appearance, and common sense.

Regular Work Gives Background

Since Milwaukee-Downer gives a degree of B.S. in fine or applied arts, and since as many as twenty-four art credits may be offered toward the B.A. degree, a number of the college students are electing such studies as will afford them an excellent background for the special training in occupational therapy. Such students are carefully advised by the director of the department of occupational therapy during their college years. For example, certain courses in bacteriology, chemistry, economics, education, psychology, hygiene, and physical education are recommended.

In general, the course in occupational therapy consists of work in theory and crafts for thirty-two weeks, and then twelve weeks of hospital work under a competent director. Among the lecture courses given in the thirty-two weeks of study are courses in physiology, in abnormal psychology, and in the theory of occupational therapy. Physiology includes kinesiology, applied anatomy, sanitary science, and special lectures on heart disease, tuberculosis, and orthopedics. The abnormal psychology lectures includes conceptions of insanity, functional and organic disorders of the central nervous system, with special emphasis on neurasthenia and the mental condition of all sick people. The course in the theory of occupational therapy includes the application of occupational treatment to all pathological conditions, hospital ethics and conduct, and organization and administration of a department of occupational therapy.

	Hours per week	Weeks
Design lectures and studio work	4	32
Metal working jewelry and silversmithing	12	16
Book binding	3	16
Weaving warping and threading (2 and 4 harness looms)	6	32
Woodwork toys, simple furniture	4	32
Basketry—reed and raffia	3	32
Miscellaneous crafts chair caning, rake knitting, pine needles, dyeing and block-printing	2	32
Mechanical drawing	4	32
Physiology for occupational therapy lectures	1	16
Principles of sanitary science—including medical and psychological phases of rehabilitation	2	16
Kinesiology—12 lectures and demonstrations	..	..

The curriculum of a forty-four weeks' course in occupational therapy leading to a diploma has been evolved through the close cooperation of the academic departments of the College and the workshop of Columbia General Hospital, with the excellent department of art in the College. On this page is a summary of the work as given in 1920-21:

It is interesting to note that of the above work, all except the mechanical drawing, metal work, and design, was organized especially for the occupational therapy course. As such highly specialized work as occupational therapy demands courses planned primarily for that purpose, Milwaukee-Downer College considers this one of the strong points of its course.

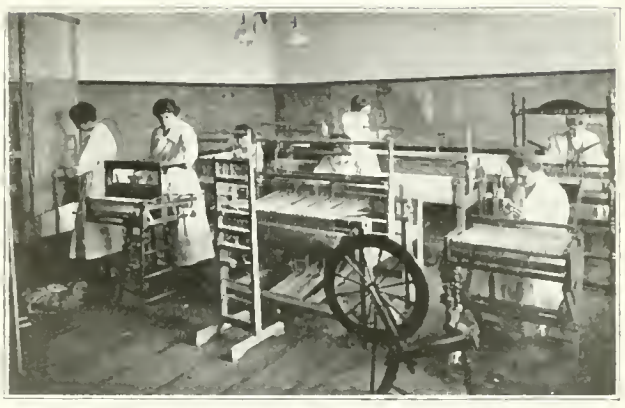
That students may get the hospital point of view while learning the crafts, one half-day a week is spent in observation in Columbia General Hospital under its director, Miss Goodman, who is also supervisor of practice teaching.

Dr. H. C. Shumm has given the lectures on kinesiology at Columbia Hospital for the students and for members of the Wisconsin Association of Occupational Therapy. Misses Mabel Frame and Julia Hooker are the instructors of the crafts. Professor Arnold gives the mechanical drawing, Professor Hoffstadt the sanitary science, Assistant Professor Jewell the physiology, Mrs. Carl H. Davis the lectures on abnormal psychology, and the theory of re-education, and Professor Partridge, head of the department, the design. Examinations in all the work must be successfully passed before the student is recommended for hospital practice teaching. Of this work, one month in Columbia Hospital is required of every student. In this curative workshop the student, under the guidance of the director, meets the various problems that come up in a general hospital and receives special training on the curative side of orthopedic cases. The student learns the use of the McKenzie apparatus for functional restoration, learns how to make graphs, and to keep records showing improvement in range of movement. She also learns the relation between physiotherapy and occupational therapy. These practical items in the training at Columbia Hospital are features of the course.

For the last two months of practice teaching the student is assigned to any one of the other institutions in the city, according to the work in which she wishes to specialize; those who expect to work in the mental field go to Milwaukee County Hospital for the Insane, and Milwaukee Sanitarium; for tuberculosis cases they go to Muirdale Tuberculosis Sanitarium; and for children's work to the Milwaukee Children's Hospital.

That occupational therapy has a vital place in hospitals and sanitariums has been proved in this state at least. Up to 1919 the department at Muirdale Tuberculosis Sanitarium, under a former student of Milwaukee-Downer

Class in woodwork at Milwaukee-Downer College.



Occupational therapy class in weaving, Milwaukee-Downer College.

College, was the only one of its kind in Wisconsin. Since then, the work has been established at the Milwaukee Children's Hospital, Milwaukee County Hospital for the Insane, Milwaukee Sanitarium (mental), and Columbia General Hospital. Miss Goodman is the director of the latter; former students of Milwaukee-Downer College are in charge of the departments of the other institutions.

The Wisconsin State Association of Occupational Therapy was formed a year ago with Milwaukee-Downer College faculty and students as a nucleus. It is now a working organization, with Dr. Gaenslen as honorary president and Miss Goodman as president.

Milwaukee-Downer College feels that its course is especially strong in two respects. First, as occupational therapy is a profession peculiarly adapted for women of education, tact, and sympathy, it is most fitting that the course be given at a woman's college. Second, it meets the lack which educators have agreed has heretofore been the greatest weakness of all occupational therapy training, namely, that of the hospital point of view. The half-day a week spent by the student in the hospital workshop for observation and help during her instruction in the theory and crafts prepares her to go into the hospital for her practice teaching, informed as to the hospital etiquette and method of attack.

ST. LOUIS SCHOOL OF OCCUPATIONAL THERAPY

By IDELLE KIDDER, Director of the Missouri Association for Occupational Therapy, St. Louis, Mo.

ONE of the activities of the Missouri Association for Occupational Therapy is the St. Louis School of Occupational Therapy.

The aim of the Association is to train and qualify women to teach occupational therapy; to stimulate an interest in, and extend the use of occupations as a curative measure for physical and mental ills; and to carry out activities for the betterment of the industrial and economic conditions of the physically and mentally handicapped.

The school has been in existence since December, 1918. At this time Miss Alice H. Dean, a graduate of the Henry B. Favill School of Occupations, of Chicago, was made director. Four classes received their training under Miss Dean's instruction.

The course of instruction was materially lengthened for the fall class which began its training September 27, 1920. A head instructor was put in charge of the school with an assistant whose time is divided between the school, and the Association's shop for handicapped. A special instructor in weaving was employed for the school and the various hospitals where the Association directs the work of the occupational therapy departments. An instructor in woodwork, from the David Ranken Jr. School of Mechanical Trades, was engaged to instruct the class, for three hours each Saturday morning throughout the course, in regular bench woodwork.

Generally those admitted to the classes have been over twenty-one years of age.

A college education or its equivalent is the desire of the Association.

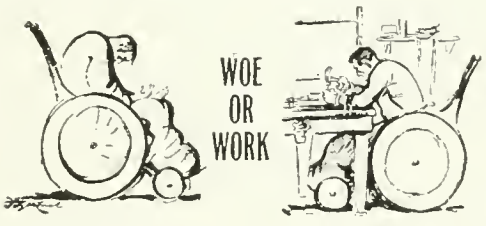
Medical certificate of health.

Earnestness of purpose, pleasing personality, willingness to work with mental and tuberculous patients in any hospital in or outside of St. Louis.

Young women who are definitely planning to enter a school of occupational therapy are earnestly advised to include in their junior and senior years at college, physiology, anatomy, psychology, sociology, theory and applied design, including work with color; also during some of their vacation time receive instruction in manual training and metal work.

Training

Craft instruction and lectures five days a week for six months, hours, 9 a. m. to 4 p. m. Woodwork, three hours every Saturday morning for six months.



Required hospital practice training, following school work, three months.

Tuition $100.00. Tools and supplies, about $50.00.

Instruction is given, for one hour or more each morning throughout the entire six months, in theory and applied design.

Basketry and metal work, thirty days, or about one hundred and thirty-four hours.

Weaving, including the study of loom construction, warping, plain and pattern threading, pattern designing, plain and pattern weaving, nineteen days, about ninety hours to weaving.

Bookbinding and beadwork. Sample pamphlet and bookbinding, including portfolio and notebooks, eighteen days, or about ninety hours.

Stenciling and pottery, twenty days, or about one hundred hours.

Leather work and wood carving, including wood inlay, twenty days, or about one hundred hours.

Manual training, instruction in woodwork tools, and their proper use and care; reading of blue prints, making simple construction designs to scale; various articles made, for practice in planing, sawing, the use of the chisel, joining and wood finishing; twenty-four mornings, or seventy-two hours.

Lectures: fifty hours. These lectures are given, free of charge, by specialists in St. Louis, who are authorities on their subjects. One lecture on each of the following: "Anatomical Demonstration," R. J. Terry, M.D.; "Psychology of Beauty," Mr. E. H. Wuerpel; "Abnormal Psychology," F. M. Barnes, M.D.; "Social Aspects of Occupation," George H. Mangold, Ph.D.; "Occupational Therapy in Mental Diseases," F. M. Barnes, M.D.; "Technique of Hospital Social Service and Relation of Occupation to Social Service," Miss Blanche Renard; "Injuries to the Nervous System," Ernest Sachs, M.D.; "Frequent Conditions in Orthopedic Surgery," Philip Hoffmann, M.D.; "Occupational Therapy in Orthopedic Surgery," J. Archer O'Reilly, M.D.; "Convalescence in Surgical Conditions and Occupational Therapy in Surgical Conditions," Carroll Smith, M.D.; "The Relation of Occupational Therapy to Vocational Training," Mr. Lewis Gustafson; "The Work of the Federal Board for Vocational Education," Mr. T. L. Johnson; "Occupational Therapy in Neurasthenia," Sidney I. Schwab, M.D.; "Occupations for the Blind," S. M. Green; "Fatigue," Edgar James Swift, Ph.D.; "Hospital Etiquette," H. W. Loeb, M.D.; "The City Institutions," Cleveland H. Shutt, M.D.; "Hospital Ethics of the Occupational Therapist," Miss Idelle Kidder; "Business Responsibilities of the Occupational Therapist," Mrs. Frank V. Hammar; Address, Malvern B. Clopton, M.D., president of the Association.

Two lectures each on the following: "Principles of Design," Mr. E. H. Wuerpel; "Psychology," L. B. Alford, M.D.; three lectures on "Hospital Nursing" (Etiquette of the Nurse), Miss M. A. Gillis, R.N.; five lectures on "Tuberculosis," J. J. Singer, M.D.; nine lectures on "Kinesiology," F. H. Ewerhardt, M.D.

Change of Location of the School

The director of the Missouri Association for Occupational Therapy believes that the psychology of work and of the patient, and the application of the one to the other, cannot be understood by a student when the school for training occupational therapists is conducted entirely outside of a hospital. Without the hospital influence and an opportunity for observation of the various types of patients, students unfamiliar with medical and surgical convalescence cannot during their craft training understand the mental conditions and various attitudes of patients due to disease or hospital residence. When the various lectures covering the many branches of hospital treatment and care for the patients are given to students during the days they are witnessing patients under treatment in an occupational therapy shop, these students much more readily grasp the meaning and importance of the therapeutic object of the work. The mere daily coming to a hospital, with a limited amount of going about, gives the aides much which is valuable in training, though they know they are as yet no part of the hospital. They learn something of other departments conducted within a hospital which are as important and as necessary for the patient as the one they are preparing to enter.

These points were presented to the hospital commission and the manager of the St. Louis City Hospital, and immediately permission was granted the Missouri Association for Occupational Therapy to conduct a school in the workshop of the hospital.

The occupational therapy workshop in the St. Louis City Hospital is a large octagonal room, well lighted and ventilated, which had been a ward containing fifty beds. From this opens what had been a small sun parlor but is now used as an office by the City Hospital superintendent of occupational therapy. From a private hallway are rooms for the use of the department, such as a general supply room, a dressing room, a kitchen, and what had been a bath room is used for the storing of reed and the preparation of it for the use of patients. For lecture purposes, one of the rooms is loaned by the public school

Part of the 1920 class at the St. Louis School of Occupational Therapy.

department whose quarters are situated across a hallway from the occupational therapy department, the proximity of which is of great advantage in making possible close cooperation in caring for patients of school age.

The present class in training received one-half of its instruction at the central location of the Association. In December the school equipment was moved to one section of the hospital workshop and has since been most successfully conducted there.

This experiment, and only as an experiment was it undertaken, owes much of its success to the cordial interest of the hospital commissioner, the hospital manager, and his staff, the superintendent of nurses, and her pupils (who receive two weeks' instruction in occupational therapy in the hospital workshop), and the social service department; in fact, each department of the hospital has been most helpful in its cooperation and friendly attitude.

Association Supervises O. T. Departments

Three of the city institutions have occupational therapy departments which are supported by the city and supervised by the director of the Missouri Association for Occupational Therapy. The Association also maintains and directs the work for Barnes Hospital, and directs the

occupational department at the Night and Day Camp for the St. Louis Tuberculosis Society.

The City Sanitarium (for the insane) averages about 2,400 patients, the Robert Koch Hospital (for tuberculosis) about 185, and the St. Louis City Hospital (general) about 575.

By a city ordinance last summer a budget was provided to employ for each of these institutions one superintendent and two assistant occupational therapists, also supplies and equipment, (all of which had previously been financed by the Missouri Association for Occupational Therapy), with the exception of Koch Hospital, which was a new undertaking and where no sum was asked in the beginning for assistants. The director of the Association recommends to the hospital commissioner occupational therapists for appointment, and under his sanction appointments and policies are carried out.

Supervision of Hospital Practice Training

When the class has completed its work in the school, the head instructor goes with the group (undivided) to the city sanitarium to assist the superintendent of the department in the first instruction of the students with the patients. Later the class is divided, and rotates, in order that each group may have half of its hospital practice training in city hospital, the head instructor giving her time where she is most needed.

Opportunities for Second Year Graduates

Assistant occupational therapists can hold their positions but one year, and these vacancies are filled by appointments made from students who have successfully completed the entire course of training. Under this arrangement a uniform plan is possible whereby the students are under unbroken supervision through their school work and practice training, with the added experience of one more year for those who qualify and obtain positions as assistants.

Factors Which Made the School Possible

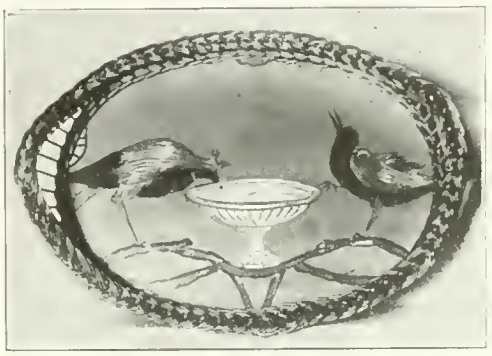
The small group which first banded together and formed the nucleus for the National Society for the Promotion of Occupational Therapy, under the leadership of Dr. William Rush Dunton, Jr., is largely responsible for the united efforts to train young women as occupational therapists, and make it a profession which can be used with great advantage for many types of patients, not only in the hospital, but the home, the industrial plant, and the shop for the handicapped.

Through the national society and the Henry B. Favill School of Chicago (when trained young women were so needed in the war), Mrs. Eleanor Clark Slagle set the standard for the occupational therapy school and gave the vision for the future development.

When Dr. G. Canby Robinson, then dean of the Washington University School of Medicine, with Mrs. Elias Michael of the St. Louis Women's Committee of the Council of National Defense, first considered plans for assisting in war work, to train young women as occupational therapists, wise judgment was used for the success and development of such a school by forming a board of trustees, each member of which was selected with the idea of bringing together a group representing those who were keenly interested in the plan and who were authorities in St. Louis upon several phases of special education, hospital management, the law, and general business matters.

This board called upon Mrs. Slagle to visit St. Louis and she approved of the plans that had been made, and recommended the first director for the St. Louis School.

It would seem wise to urge institutions and individuals interested in occupational therapy to advise with the president of the National Society for the Promotion of Occupational Therapy if they are contemplating opening departments in institutions, or need special information, and thus get in touch with existing organizations.



TOLEDO NURSE ASSOCIATION UNDERTAKES VOCATIONAL INSTRUCTION OF SHUT-INS

The Toledo District Nurse Association received a bequest during the last year which enabled it to purchase new property at a time when the need for new headquarters was very urgent, and all efforts to rent adequate space had been unsuccessful. The new house has on the lower floor the offices and conference rooms of the Association. Here hundreds of phone calls are received every week, for the nurses to attend all kinds of sickness in all parts of the city. It is here that free instructive literature on various health subjects is given out. The prevention of sickness is as much one of the aims of the Association as its nursing care. On the upper floor is the dispensary, equipped with all modern appliances. Clinics are held here daily. The service is free to all women and children who cannot pay. Those who can are asked for a small fee. The operating room for minor operations, and rooms for the treatment of the eye, ear, nose, and throat are upstairs, also.

The appalling results of undernourishment prompted the formation of a nutrition class where children who are diagnosed as undernourished by the physician, are taught the principles of a well balanced diet. The dietitian visits the homes, also, to instruct the mothers.

The Association had long wanted to be able to give cripples, or patients confined to their beds day after day, something to do, and this year the desire was fulfilled when a gift was received for this purpose. One worker now gives half a day to vocational teaching of shut-ins. The results have been very gratifying. Several women who have been confined for years without being able to do anything useful are now happy in the new found occupation of making rag dolls, collar and cuff sets, organdie flowers, etc. A man whose left side is paralyzed was furnished with a stamping outfit and is now selling signs, cards, and stenciled oilcloth mats.

The total number of patients treated in the year 1920, either in the dispensary or the districts of the city, was 10,140. Since Toledo has had the Community Chest system, $4,073.33 a month has been given to the Association for its work.

Good health and good sense are two of life's greatest blessings.—Publius Syrus.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR.

Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York

RELATION BETWEEN THE HOSPITAL AND THE OUT-PATIENT DEPARTMENT*

BY CHARLES F. NEERGAARD, NEW YORK, N. Y.

THE same problems confront hospitals and dispensaries today which exist in the business world: high costs, scarcity of working capital, and the general apathy and let-down of post-war days. The conditions of unemployment and rapidly dwindling savings point logically to a greater volume of dispensary service, and more than ever before is it incumbent upon all who have the responsibility of the management of our institutions to conserve their resources, both money and effort.

To offset high wages and low production per man, and to keep their profits on the right side of the ledger, business managers have been obliged to study every step in their productive process—to eliminate waste motion, duplication of effort, and to discover new short-cuts to greater efficiency and teamwork. By such methods only can business succeed.

The organization of our hospitals is a logical combination of the business man, represented by the board of trustees, the administration, represented by the superintendent, and the medical staff. The medical staff represents the factory production and the superintendent the general manager, who coordinates all. It is the proper function of the trustee to bring to the organization his experience and knowledge of business efficiency.

The Dispensary Development Committee of the United Hospital Fund has been organized, as its name implies, to study and improve dispensary work in the city of New York, and by the establishment of standards and publication of results, to extend its influence wherever dispensary work is done. It is through the generosity of this committee in furnishing the Associated Out-Patient Clinics with a secretarial staff, that this organization is enabled to renew its work after several years' inactivity. I am indebted for the data of this paper to the report of Dr. Gertrude Sturges of this staff, of a study which she has just completed in eleven dispensaries of New York, seven general hospital dispensaries, and four special institutions.

To the average layman, and I might say, to the average hospital trustee, the out-patient department is a minor activity of the hospital, a place where the walking sick poor can go for treatment. Few trustees even realize that in its contact with the public through vital preventive work and after-care, as well as through treatment of sickness, the dispensary ministers to from ten to twenty times as many patients as the hospital. In one institution with which I am familiar, the hospital with its three hundred beds cares for less than five hundred individuals per month, whereas the out-patient department with its daily attendance of over three hundred, treats between six thousand and seven thousand individuals per month. Manifestly, disease caught in its incipient stage and checked in the dispensary before the patient requires hospital care, means economy to the community; and efficient after-care and follow-up which prevent recurrence and insure a complete cure after hospital treatment, conserve the expense of hospital care.

But all this is perhaps academic. I merely wish to emphasize the importance of the dispensary field, which, I believe, is rapidly receiving proper recognition in the minds of the public generally.

The Medical Staff

In every out-patient department the greatest problem is staff personnel. The younger men are attracted to dispensary work by three motives—the good they can do, the hope of a future hospital appointment, and what they can learn. While recognizing that the medical profession, more than any other group in the community, is unselfish in its character, we must realize that with a living to earn, the second and third reasons are the most potent.

The relation between the medical staff of the hospital and that of the dispensary, the method and term of appointment of the staff, the opportunities for advancement from the dispensary to the hospital staff, the character of the service given in the dispensary by senior physicians, the privileges granted the junior dispensary men in the hospital, and similar points, were taken up in the survey to which I have referred.

In all except two of the institutions studied, there exists a more or less definite relation between the staffs of the hospital and the dispensary. In three, one special and two general institutions, the staffs of the hospital and dispensary are identical, although the junior grades of the dispensary staff do not have independent hospital privileges. In two hospitals, one special and one general, the membership of the hospital staff and the dispensary staff are the same except for the junior grade of the dispensary staff, which are not represented in the hospital. In actual practice this relation seems to work out

*Address delivered at meeting of Associated Out-Patient Clinics of New York, May 26, 1921.

practically the same as when the staffs are identical; that is, the lowest grade of physicians in the dispensaries have about the same privileges whether they are technically members of the hospital staff or not. Four institutions have established a relation between the hospital and dispensary staff through having one grade of the hospital staff act as chiefs of clinic. The grade of hospital staff acting as chief varies widely, however.

In all except two instances, work in the dispensary is considered a stepping stone to hospital appointment. As a rule, nominations to the trustees or managers are made by a committee composed of the heads of departments. In one instance the hospital superintendent is a member of this committee and in another members of the board of directors also sit on this nominating committee.

The possibilities which the last two methods suggest are valuable. Coordination and team play are vital to success. A committee which includes the trustees, the superintendent, and the chiefs of the medical staff, combining as it does the three factors in the institution organization, is the logical steering committee to give intelligent discussion to the many problems that face all departments.

The actual amount of time spent in the dispensary by the hospital attendings varies greatly, not only between different institutions but in the same institution. The general procedure seems to be for the senior surgeon or physician to visit the dispensary about once a week to consult with the junior men on a group of cases which they have worked up. It seems to be a general rule in the institutions visited that any physician working in the dispensary may have the privilege of following the treatment of any of his cases in the hospital, although in most instances he has no responsibility whatever for their treatment there. The following of cases is generally left to the initiative of the junior men, with the result that through diffidence or preoccupation they do not take advantage of the privilege nominally offered, and thus lose the educational advantage of observing the complete cycle of disease and treatment, with stimulating contact and consultation with their superiors.

The privilege of the use of private rooms by the outpatient staff varies greatly, but in general, if there are vacant rooms, they may bring in their private patients for treatment. In several institutions such treatment is supervised by the attending.

Medical Care of the Patient

It is the custom in all the hospitals visited to refer the patient to the same service in the hospital as cared for him in the dispensary. In only two hospitals, both special institutions, does the same physician actually treat the patient in the hospital as cared for him in the outpatient department. In all the other institutions the senior members of the hospital staff have the responsibility for the care of the patient in the hospital, and the junior men who worked up the case in the dispensary, although they have the privilege of following cases into the hospital, have no responsibility for their care there, and usually do not observe the treatment of the case. In one hospital the seniors have usually seen the patient in the dispensary before his admission to the hospital. In three the senior may have seen the patient in the dispensary before his admission to the hospital, this depending upon the physician's custom of dispensary service. In the other institutions it is not customary for the seniors to have seen the patient before his admission to the hospital.

In the four hospitals where seniors do not visit the dispensary, some member of the staff is active in both hospital and dispensary and serves as liason officer. With a very active liason officer, or if the system of exchange of records between the hospital and dispensary is adequate, sufficient data regarding the patient's former treatment are available so that continuous care of the patients is not interfered with by a change in the responsible personnel. If, however, no information as to the dispensary examination and treatment, other than a statement of diagnosis, is furnished by the dispensary to the hospital, and a different physician is in charge of the case, a distinct waste of professional skill is apparent. This waste is usually greater in general medicine and the specialties than in surgery, and obviously increases with the length of time the patient has been under the care of the dispensary, although varying widely with the degree of professional service rendered by the dispensary staff.

Records and Information

The importance is evident of having full information as to previous examination and treatment of patients in the dispensary provided the physician responsible for their care when they are transferred to the hospital, and it seems obvious that the minimum information to be provided, unless the hospital and dispensary staff are identical and all actually work in both places, should be a summary of the history, physical examination, laboratory examination and treatment.

From the standpoint of economy it seems imperative that the record of laboratory examinations such as x-ray, Wassermann, and other expensive procedures, should be transferred between the dispensary and hospital whenever a patient is referred for treatment.

The survey indicates a wide variation in practice. In one institution the patient's record in hospital and dispensary are identical, one record room serving both departments. In one a copy of the dispensary record is made and permanently incorporated in the hospital record. In another the dispensary record is incorporated with the hospital record during the period of the patient's stay in the hospital. In one the original dispensary record is permanently bound with the hospital record. Another sends an abstract of the dispensary record containing the essentials of history, physical findings, and laboratory report, to the hospital when the patient is transferred. In the other institutions the dispensary record may be sent over to the hospital on request.

As to the amount of information regarding hospital treatment that is provided the dispensary, the practice usually corresponds to that in use for providing information to the hospital of previous dispensary treatment. In five institutions the hospital record is sent over to the dispensary at the request of the physicians working there, but in actual practice considerable variation in the use of these records is observed. In two hospitals there is a ruling that the hospital records are not allowed out of the record room, and if a dispensary physician wishes to consult the record, he must personally visit the record room. This inconvenience must be a great deterrent to the busy physician wishing data on his dispensary cases.

The wide variation of procedure indicates that in this most important matter of records much waste effort may be eliminated. If the medical work of the dispensary has been of a sufficiently high grade to meet the standards of a first rate institution, the record of this work should be valuable enough to be of use to the hospital intern in working up the case, and even to the hospital attending himself.

As noted in my summary, only certain hospitals, by their interchange of records, make sure that expensive laboratory work is not duplicated, trusting to the laboratory to catch any such duplicate orders, or to the physician acting as liason officer, or even the patient himself, to call attention to the fact that previous laboratory work has been done. Although in practice little laboratory work may be duplicated, the system, or lack of it, seems to have little justification.

Summary

The Associated Out-Patient Clinics offer us a great opportunity for the interchange of ideas. When we see how things are done elsewhere we may properly ask ourselves, "Are we making the most of our opportunities for service, and getting the best results for the money and effort expended?"

My own deductions from the data presented are these: that the relations existing between the hospital and its dispensary should be more close; that a small joint committee in each institution composed of trustees, attendings, and the superintendent, should be responsible for coordinating the two departments; that the medical staff in both hospital and dispensary be a unit so far as practicable, the chief of each service being responsible for organization and methods down through the clinic; that the men higher up should give more active supervision, consultation, and teaching in the dispensary, which would bring the junior the instruction and advice to which they are entitled, to the patient prior contact with the physician who will care for him in the hospital, and to the case a continuity of treatment. The dispensary staff should be expected rather than permitted to follow cases transferred to the hospital, so that they can observe and study the complete cycle of disease and treatment. Such an organization, coupled with inspiring leadership on the part of the seniors, would, I believe, go far in remedying the problem of a dispensary staff, and would result in a waiting list rather than vacancies. It would certainly improve the quality of dispensary work.

In the matter of the interchange of records, the economy of time, money, and effort would seem to set an irreducible minimum. A system which requires the dispensary physician to leave the clinic and make a personal visit to the hospital record room to look up a case is far from efficient. A system where the record of weeks of treatment in the dispensary, with possibly expensive laboratory and x-ray work, is not transferred to the hospital with the patient, is certainly wasteful. The skill and time of the physician is the hospital's capital, and from a business standpoint everything known about and done for a case in any department of the hospital should be immediately available to the physician in whatever department the patient may be.

FREEDOM JUSTIFIES ITSELF

"Our long established policy of allowing the maximum amount of personal freedom compatible with the existing mental condition has been justified in the greater contentment of our patients while undergoing treatment and in a lessening of the aversion of persons suffering from nervous and mental diseases from seeking admission. Of the total number of admissions during the year, 52 per cent came to us on voluntary application. In spite of an almost constantly inadequate personnel, we have not been obliged to curtail the usual degree of liberty allowed, and it is a pleasure to add that this liberal policy has led to no serious mishap during the year."—*1920 Superintendent's Report, Butler Hospital, Providence, R. I.*

NURSING SPELLS OPPORTUNITY IN LARGE LETTERS

By NANCY E. CADMUS, R.N., Superintendent of the Manhattan Maternity Hospital and Dispensary of the City of New York.

Conditions today will not permit of nursing being regarded simply as a profession open to women; the experiences of the past six years have forced nursing to the point where we are compelled to stress it as one of the vital interests of society at large.

Because the preparation and education of the nurse is so inseparable from the hospital, the public should also break away from the idea of the hospital merely as an organization, and accept it as a thing "persistent" in our social life, that is, regard it as an institution in a very broad sense.

The recent war has given the "trained nurse" a new meaning, indeed so rapid has been the growth in the demand for professional nurses that dismay has been created in the field of supply, namely, the schools of nursing. Doubtless we all are well aware that a distinct shortage of applicants for these schools exists. Also we all know that some of the shortage may be attributed to the existing economic and social conditions, but how shall that which is not due to these be accounted for? Shall the hospital be regarded as a charitable institution, or is it a thing "persistent" which functions either to profit or loss in the community?

Do these schools of nursing mean other than a department of the hospital through which the nursing care of the patients is accomplished, and ultimately from which each student nurse may expect to find a place in the ranks of the graduate, trained nurses, whose quantitative value in the community is not yet so well defined as is that of the other professions?

Assuming that all agree that the demand for nurses is a social problem, who are they that may be said to be qualified to make constructive criticisms and suggestions based upon a correct and comprehensive knowledge of hospital and school as the result of a painstaking study?

Recently a questionnaire was sent to all the student nurses in the schools of this city connected with the New York City League for Nursing Education.

One question was, "Were you opposed by your immediate family when you selected the profession of nursing?" Eighty per cent answered in the affirmative, some of the reasons given being the following: "not strong enough," "could not endure the hard work," "would lose social caste because of the menial nature of the work," "fear effect upon the morals," "living conditions for the nurses in the hospital so bad," "an abhorrence of the contacts, social, physical, and moral, the young woman must experience," "long hours," etc.

If nursing is inherent in social affairs; if the hospital and school are "persistent" in our social purposes; if the well equipped nurse is one of the demands of the public, why should this field for true and effective service be regarded by the fathers and mothers as unsuitable for their daughters?

This question of supply to meet the ever growing demand is a responsibility none should disregard. The matter offers a field for the moral, social, and financial support of all, it is one that affects the high and low, the rich and poor, because of the part nursing must ever play in the conservation and preservation of the health of the community.

At the end of twenty-five years of activity in the nursing world, the tribute I would pay my profession is this, it is worthy of the best and finest of the womanhood of America, it spells opportunity in large letters.

Venereal Diseases and the Hospital

Conducted by Alec N. Thomson, M.D.
Director, Department of Medical Activities
The American Social Hygiene Association, 105 W. Fortieth St.,
New York City

VENEREAL DISEASE AND THE HOSPITAL

The American Hospital Association recently sent the following bulletin to its institutional members on the subject, "Venereal Disease and the Hospital":

Why should hospitals not be a factor in the present venereal disease program? The new and modern attitude of hospitals is coming. Read the facts.

While the bulk of all active public health work lies in the out-patient department, it is clearly recognized that some individuals must at a strategic time receive bed care. This is as true of venereal as of other disease, yet hospitals in the past have made little or no provision for bed care for these diseases. If, from the standpoint of the sanitary code, we exclude from general hospitals those venereally infected persons who require quarantine, and, from the standpoint of the criminal code, those who require custodial care, there remains only a comparatively small number of patients that require admission to general hospitals primarily from gonorrhea or syphilis. A small number of beds would meet this need.

If the indifference or antagonism is due to fear of the disease or of cross-infection, it is quite time that hospitals change the situation. Syphilis is not markedly different in degree of communicability from pneumonia or typhoid; gonorrhea is a no more difficult problem than any other condition having an infectious discharge; and chancroid and gangrenous balanitis require no more care to control cross-infection than that usually given to ordinary open infected wounds. Cases of cross-infection are rarely seen outside of children's wards, and never where reasonable hospital technique exists. When encountered, gross negligence, ignorance of the patient's condition, or some other preventable factor is responsible.

A few of the patients suffering from venereal disease are from time to time, and for various reasons, in urgent need of bed care; and should be considered by the hospital under the same admission regulations as other patients. They should not be tabooed as a group nor should they require deception in admission when the venereal disease is a secondary diagnosis.

The present situation in most general hospitals is far more dangerous and to be regretted. The existence of coexisting or complicating venereal disease is often not recorded, leaving nurses and other attendants in ignorance of the condition, and syphilis in an appendix case is just as contagious as when the only disease. This deception is justified by the intern or attendant making the discovery, because of the fact that the patient really needs the hospital care for the other affliction. The discovery is often difficult because the outside physician has warned the patient of this policy of the hospital. Admit venereal disease and plainly label it as such. The psychology of all students will insure against any cross-infection. Service to your community requires that you refuse admission only for valid reasons; it does not require that any diagnosis be kept from the records or charts.

Conference Votes Yes

The All-American Conference on Venereal Diseases has officially declared that patients requiring hospital treatment for gonorrhea and syphilis should be admitted to general hospitals. This Conference, composed of a large group of recognized authorities on all phases of the control and eradication of venereal disease, met in Washington during the week of December 6-11, 1920, for the purpose of comparing and evaluating the venereal disease control methods employed in various parts of the world.

In taking up the subject of venereal disease in relation to the hospital or the hospital in relation to venereal disease, thought must be given to social service. Social service is recognized as essential to the efficient organization of venereal disease control work, both in the hospital and in the out-patient department. It renders a service to the patient, to the hospital and clinic, and to the community; and is a definite contribution to the venereal disease program of the state and municipality.

If there is a question left in your mind as to the wisdom of the fundamental policies of the campaign or as to what their policies are, ask it now and get an answer. The policies include the admission of venereal disease patients to general hospitals. The following facilities and authorties invite the opportunity to be of service to you:

1. The United States Public Health Service, Division of Venereal Diseases, Washington, D. C.
2. The Medical Department of the American Social Hygiene Association, 105 West Fortieth Street, New York City.
3. The board of health of any state.
4. The Service Bureau on Dispensaries of the Association offers service on any of the phases of control and eradication of gonorrhea and syphilis from the standpoint of the hospital and dispensary. The out-patient committee is cooperating in this work through its member, Dr. Alec N. Thomson, medical director of the American Social Hygiene Association, who is in a peculiarly strategic position to assist the Bureau. Address 15 West Forty-third Street, New York City.
5. This office will follow up any question to verify statements and get facts.

Some one person in every hospital must be the first to learn new ideas and new thought. When you are convinced what should be done in your hospital, take the matter to your trustees and convince them.

PUBLIC HEALTH COMMITTEE REPORTS ON DISPENSARY SITUATION

The *Public Health Reports* for November 19 contains a discussion on "The Present Status of the Venereal Disease Clinics," by John W. Hart, regional consultant, United States Public Health Service. This was written as a result of a survey of 444 cities of over 15,000 population, made in February, 1919, by the United States Public Health Service.

The questions covered the following points: location of the clinic, equipment, methods of sterilization, methods of recording cases and histories, personnel, cost of operation, and standards for clinics.

In considering the ideal location for the clinic it was decided that it is best to have it centrally located—in office or municipal buildings—in order that opportunity be given the patients to conceal the nature of their visits.

As for equipment, the following requirements were considered as essential for adequacy: Necessary appliances

for the treatment of anterior and posterior urethritis with their complications; appliances for the proper preparation and administration of arsphenamine and neoarsphenamine; apparatus for the sterilization of instruments, etc.; a water still, and sufficient supply of drugs for the treatment of gonorrhea, syphilis, and chancroid, according to the requirements issued by the United States Public Health Service. It is interesting to note that 56.8 per cent of the clinics surveyed were equipped with live-steam sterilization and only 3.9 per cent were equipped with chemical sterilization.

The records consisted of the history of the patients and record of treatment. A complete history is one which gives the name, address, age, sex, color, marital condition, source of infection, and the usual information of the family history, past history, present illness, date of exposure, period of incubation, treatments received prior to applying to the clinic, and general information. Records of treatment must include the patient's condition at the time of treatment, date, and type of treatment given, with notations of reactions, serological examinations, and other aids to control treatment.

Personnel of these clinics are supplied by the city, state board of Health, private organizations, or by the hospital in which the clinic is located.

The total cost per month per clinic is on the average $376.71. Of the clinics surveyed, the average cost per patient per treatment is estimated to be $1.80.

The 202 clinics from which data were received were divided into five classes, according to equipment and efficiency. Four of the clinics were found to qualify for standard "A"; seven qualified for standard "B"; fourteen for standard "C"; fifty for standard "D"; and the remainder of the clinics qualified for standard "E."

In the following, the first column gives the requirements for a standard "A" clinic. Types "B," "C," and "D" are like "A" with the exceptions indicated.

Class "A"	Class "B"	Class "C"	Class "D"
Central location.			Equipment omitted.
Adequate equipment.			
Adequate means of sterilization			
Complete histories.			
Complete record of treatment.			
Convenient source of distilled water		No distilled water.	No distilled water.
One or more nurses.			
A social worker.		No social worker.	No social worker.
A clerk.			
Open at least five days a week.	Open three days.	Open three days.	Open three days.
Open four hours a day.	Open three hours.	Open two hours.	Open two hours. No night hours.
Night hours.			
Good treatment.		Fair treatment.	Fair treatment.
Conveniently accessible laboratory.	No laboratory.	No laboratory.	No laboratory.
No fees charged			Fees allowed.
Properly advertised.		Not advertised.	Not advertised.
Follow-up system		No follow-up.	No follow-up.
Per capita cost $1.00.	Cost, $1.25.	Cost, $1.50.	Cost, $2.00.
Daily average attendance, 25.		Attendance, 15.	Attendance, 12.

The information relative to the clinics gained through the survey has been used to stimulate the clinics to do better work.

It is a fallacy to suppose that any schools, however good they may be, can educate. Their work is to give instruction, and as Bishop Butler said long ago: "Instruction is the least part of education."—Charles Eliot Norton.

QUESTIONNAIRE ON THE SEGREGATED DISTRICT

Three years ago the segregated district seemed firmly intrenched in many important cities of the country. Today, according to data collected by the United States Public Health Service, it has few friends. A questionnaire, sent to the mayors of all large cities with duplicates for reference to prominent men and women citizens, and chiefs of police, brought 554 replies from 212 cities. The answers to the first three questions, which asked substantially whether houses of ill-fame, in and out of segregated districts, should be tolerated, were from 80 to 90 per cent in the negative. Those to the fourth and fifth questions, which asked whether both the woman and the man should be examined medically and placed under surveillance if found infected were from 72 to 78 per cent in the affirmative. Of the 110 to eighty-six chiefs of police who answered most of all the questions from 89 to 100 per cent voted "right."

TWENTY-FOUR RULES FOR VENEREAL DISEASES FORMULATED

American Journal of Public Health, Vol. xi, No. 3, March, 1921.

The Committee on Model Health Legislation of the American Public Health Association consisted of Dr. L. E. Fronczak, health commissioner of Buffalo, N. Y.; Dr. W. H. Brown, of the Rockefeller Foundation; Dr. Carroll Fox, United States Public Health Service; Dr. H. B. Hemenway, district health officer in Illinois; Dr. W. S. Rankin, state health officer of North Carolina; Professor C. E. Turner of the Massachusetts Institute of Technology; and Mr. James A. Tobey of the American Red Cross, Washington, D. C. The committee prepared a model code for the organization of a health department and control of communicable diseases.

Twenty-four regulations were drawn up with regard to the methods of control and combating of the communicable diseases. Special rules were provided under Regulation 17 with regard to venereal diseases.

Regulation 17. *Special Rules for Venereal Diseases.*

Reports of syphilis, gonococcus infection, or chancroid made in accordance with Regulation 2 (which lists the communicable diseases, among which syphilis, gonorrhea, and chancroid are considered) of this chapter, shall be considered confidential so far as consistent with public safety. The professional attendant of any case of venereal disease shall give the patient explicit instructions to prevent the spread of the disease to others. When such patient refuses or neglects to follow the prescribed treatment, discontinues treatment, or is discharged as cured, the professional attendant shall immediately report these facts to the health officer. When any person affected or presumably affected with venereal disease does or is liable to menace the health of others, the health officer or his representative shall have the power to cause the removal of such person to an isolation hospital or other proper place, or to take any other measures authorized by law which are necessary in his opinion to prevent the spread of the diseases.

All the essential processes of life are carried on in silence. . . . The boom of the bursting bud is a poetic fancy, divorced from reality. The fruit ripens, and falls mellow to the earth, but no murmur is wrung from the parent tree. . . . Even thought, the highest function of which any living thing is capable, is a silent process.—Robert W. Mackenna.

THE EFFECTS OF SYPHILIS ON THE FAMILIES OF SYPHILITICS SEEN IN THE LATE STAGES

By Harry C. Solomon, M.D., and Maida H. Solomon, A.B., B.S., *Social Hygiene*, Vol. VI, No. 4, October, 1920.

The director of the department of medical activities, the American Social Hygiene Association, gives the following summary of this article:

The families of syphilitic patients admitted to the Psychopathic Hospital have been examined as a routine procedure. The patients are all in the last stages of the disease and are divided into three groups: (1) general paresis, (2) cerebrospinal syphilis, and (3) late syphilis without involvement of the nervous system. This division is made to determine whether the familial problem is different in cases of central nervous system involvement from those in which the central nervous system escapes. The families of 555 syphilitic patients were examined and the following findings obtained:

(1) The family of the late syphilitic abounds with evidence of syphilitic damage.

(2) At least one-fifth of the families of syphilitics have one or more syphilitic members in addition to the original patient.

(3) Between one-third and one-fourth of the families of syphilitics have never given birth to a living child. This is much larger than the percentage obtained from the study of a large group of New England families taken at random, which showed that only one-tenth were childless.

(4) More than one-third of the families of syphiltics have accidents to pregnancies; namely, abortions, miscarriages, or stillbirths.

(5) The birth rate in syphilitic families is 2.05 per family, whereas the birth rate in the New England families mentioned above is 3.8 per family, or almost twice as great.

(6) Two-thirds of the families show defects as to children (sterility, accidents to pregnancies, and syphilitic children).

(7) Only one-third of the families show no defect as to children, or Wassermann reaction in spouse.

(8) About one-fifth of the individuals examined show a positive Wassermann reaction; more of these are spouses than children.

(9) Between one-fourth and one-third of the spouses show syphilitic involvement.

(10) Between one in twelve and one in six of the children examined show syphilitic involvement.

(11) One-fifth of all the children born alive in syphilitic families were dead at the time the families were examined. This does not differ materially from the general average in the community.

(12) One-fifth of the pregnancies are abortions, miscarriages, or stillbirths, as compared with less than one-tenth of the pregnancies in non-syphilitic families.

(13) The average pregnancies per family is 2.58, compared with 3.88, 4.43, and 5.51 in non-syphilitic families.

(14) There are 3.52 stillbirths per hundred live births in the syphilitic families, as compared with 3.79 reported by the Massachusetts census, showing that there is no very marked difference in this regard.

(15) A syphilitic is a syphilitic, whether his disease is general paresis, cerebrospinal syphilis, or visceral syphilis without involvement of the central nervous system, and the problems affecting his family are the same in any case.

The family of every syphilitic patient should be examined, irrespective of the stage of the disease or the symptomatology presented by the patient when first seen. If this is done, cases of conjugal and congenital syphilis will be discovered which would otherwise be neglected. They will often be found at a period when symptoms are not active, and thus treatment may be instituted before irreparable destructive lesions have occurred. An opportunity is offered to prevent the development of such disabling conditions as general paresis, tabes dorsalis, aneurysms, and the like. The possibility of bearing healthy children may be increased. Every clinic, whether it is primarily a syphilitic clinic, a neurological clinic, a cardiac clinic, or an internal medicine clinic, should be equipped with the machinery for bringing the members of the syphilitic's family to the clinic for examination.

VOLUNTEERS IN VENEREAL DISEASE CLINICS

The use of volunteer workers as clinic secretaries and home visitors has perhaps not been tried as extensively in venereal disease clinics as in the other divisions of dispensary work. There is no reason, however, why the social service department should not avail itself of trained volunteer workers, especially in the syphilis clinic for women and children.

At the Washington University Dispensary, St. Louis, volunteer clinic secretaries have always been associated with the activities of the social service department, and are being used in connection with the department of dermatology, which cares for syphilitic patients. A very interesting article upon "The Medical and Social Care of Syphilis at the Washington University Dispensary," by Drs. Weiss and Conrad, appeared in the *American Journal of Syphilis* for April, 1920.

* * * * * *

During the war a vast amount of work in the army hospitals of the United States was carried on by volunteer workers, organized under the Red Cross. A considerable amount of the enthusiasm of these workers has been capitalized by various hospitals throughout the country, and volunteer workers are now found in many hospitals and dispensaries. They are proving to be a very valuable addition to the social service departments of some institutions.

At the Brooklyn Hospital, Brooklyn, N. Y., this volunteer work is being organized by Miss Combs, who during the war was in charge of volunteer work at one of the larger debarkation hospitals.

* * * * * *

The syphilis clinic at the Presbyterian Hospital Dispensary, New York City, has had a volunteer worker for the past few years. Practically no social service work has been done during this time with the syphilis patients by the regular social service department. The entire problem has been met by the close cooperation of the medical staff and the volunteer worker. Probably nowhere has more human social work been done in a syphilis clinic than at the Presbyterian Hospital. Arrangements are now being made to link up more closely the volunteer work with the general social service department of the hospital.

ESTABLISHING OUT-CLINICS

When patients are granted parole from an institution they are required to report back, usually, every two weeks. It is impossible for some of them to do so, on account of the distance from their homes to the hospital. It is a very good plan for the social service department to establish out-clinics in the district by obtaining the cooperation of local organizations in the matter. These out-clinics greatly simplify the patient's problem of keeping in touch with the hospital.

Hints to Hospital Superintendents

HOW TO SERVE EXTRA MEAT PORTIONS

The expression "extra meat portions" has come to mean some highly nutritive and appetizing parts of fresh meat such as brains, jowl, feet, tongue, oxtail, sweetbreads, liver, heart, and palate, which are not usually included in the regular family dietary. In our grandmothers' day, when the killing was done on the farm, these were regarded as fresh meat luxuries. Our foreign-born population today is accustomed to using them, also people whose taste has been sophisticated by foreign travel, and much eating at hotels, but to the average citizen they are unknown meats.

Many dishes made from these portions are particularly suited to convalescents, and might well be included in hospital and sickroom dietaries. Parenthetically, it might be added that most of these portions are inexpensive, in some cases they are almost given away. Their use, therefore, helps to standardize meat prices into reasonable figures by making greater use of the less popular portions of meat. Intelligent retail meat dealers, as well as the packers, recognize this point.

Most delicate appetites will react favorably to an expertly cooked sheep brain, or calf sweetbreads. Brains should be blanched, as a preliminary to cooking, by boiling for a few minutes in salt water; they should then be skinned and put into cold water. They can then be sautéed with a black butter sauce, creamed, or scrambled with eggs.

Oxtails make strong, nourishing soup; they are also very nice braised according to the following recipe:

Braised Ox Joints

Cut oxtail at joints, parboil four or five minutes, wash thoroughly, dredge with flour and sauté in butter, to which has been added a sliced onion, until well browned. Add one-fourth cup flour, two cups each of brown stock, water and canned tomatoes, one teaspoon of salt and one-fourth teaspoon pepper. Turn into earthen pudding dish, cover and cook slowly three and one-half hours. Remove oxtail, strain sauce, and return oxtail and sauce to oven to finish cooking. Add two-thirds cup each carrot and turnip (shaped with vegetable cutter in pieces one inch long and about as large around as macaroni), parboiled in salt water five minutes. As soon as vegetables are soft, add vinegar to taste, and more salt and pepper, if needed.

The inexpensive beef palate is rarely used in this country. French housewives make an appetizing dish of it in the following way:

Soak a fresh beef palate over night in cold water. Wash it well and put it to cook in boiling water and cover. After ten minutes reduce the heat, add spices and seasonings, such as a celery heart, small onion stuck with four cloves, four bay leaves and a sprig of parsley. Also add carrots or turnips as desired. Cook until the meat is tender and serve with any suitable meat sauce.

PROPER CARE OF RUBBER GOODS

There are two agencies which hasten materially the deterioration of rubber goods—heat and sunlight. At 70° C. (160° F.) articles which would otherwise last five or ten years are destroyed in three weeks or less. At higher temperatures the action is even more rapid. These facts will explain the deterioration of waterproof coats, hot-water bags, etc., which are thrown over steam radiators to dry. In direct sunlight rubber bands which ordinarily would last four to six years have become worthless in three months. The ideal storage for rubber goods when not in use is in a cool, dark place.

Oil has also a serious effect on rubber. This is particularly noticeable in the case of automobile tires and inner tubes. The oil is absorbed by the rubber and in a short time produces a soft spot. It is, therefore, of the utmost importance to remove any oil from rubber goods as soon as possible, and it pays to take precautions so that the two will not come in contact with each other at all.

HOW TO GET RID OF ANTS

Ants are attracted by various food substances, especially fats and sugars, therefore these foods should be kept in closed containers and crumbs or small amounts spilled on shelves or tables should be cleaned off at once.

The most effective way of ridding a building of ants is to find and destroy the nest by treating it with carbon bisulphid, benzine, gasoline, or kerosene. Or, if the nest itself cannot be found, oftentimes the ants may be traced to the opening or crack through which they enter. Squirting kerosene into it or plugging it with cotton saturated with oil, will in many cases drive them away.

A temporary expedient for controlling ants is to moisten small sponges with sweetened water and place them where the ants are most numerous. Attracted by the sugar, they will crawl into the sponges and may be killed by dropping in boiling water. The sponges should be baited again with the sweetened water, and, if necessary, set in different places until the colony leaves the building.

A more effective but also more dangerous method is to moisten the sponges with a syrup made by dissolving one pound of sugar in one quart of hot water, and adding 125 grains (about one-fourth ounce) of arsenate of soda. Some of the ants apparently carry this poisoned liquid back to the nest and feed it to the others there, thus gradually killing the entire colony. This mixture must be used with the greatest care, as it is poisonous to both human beings and domestic animals.

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THE exceptional purity of the talcum and its boric acid content should commend Colgate's to the physician or nurse when ordering an indifferent dusting-powder for the sick-room.

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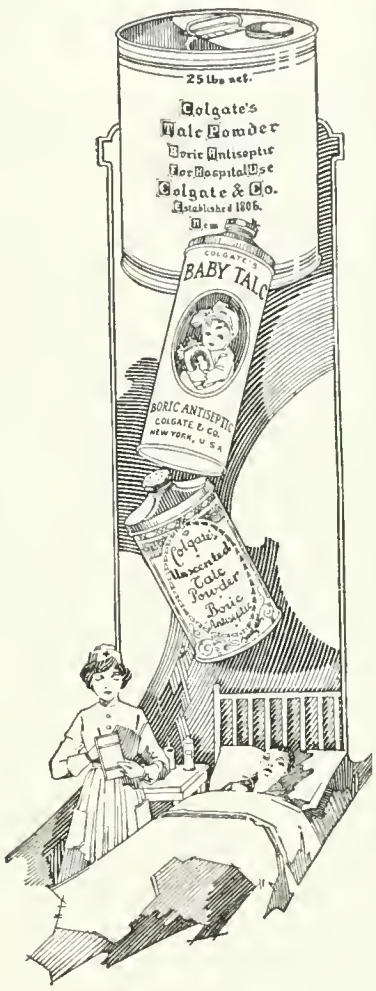

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Meetings, Conventions and Conferences

WISCONSIN'S SECOND MEETING A MARKED SUCCESS

THAT the first year of the Wisconsin Hospital Association has been one of steady growth and no mean accomplishment was evident to all who attended the opening session of its second annual convention in Milwaukee, on May 25, and heard the address of its president, Reverend Herman L. Fritschel, director, Milwaukee Hospital, and the report of its executive secretary, Dr. C. W. Munger, superintendent, Columbia Hospital, Milwaukee.

The convention was held in the Kilbourn and Walker Halls of Milwaukee's spacious auditorium. Following an invocation by the Rev. Gustav Stearns, Dr. George C. Ruhland, the commissioner of health for Milwaukee, delivered an address of welcome, at the beginning of which he traced the outgrowth of the Association from the Milwaukee Hospital Conference, organized in 1918 in the office of the commissioner of health. He characterized Milwaukee's inadequate hospital facilities, less than three beds to 1,000 of the population, as a grave situation both from the standpoint of humanity and of public health. The annual loss of $4,000,000 to the industries of Milwaukee because of sickness among employees could, in the judgment of Dr. Ruhland, be reduced to a considerable extent by the provision of adequate hospital and dispensary facilities, which would enable the sick to receive more prompt and efficient care. He expressed the hope that a large number of hospitals would develop outpatient service for periodical physical examination and health supervision. Dr. Ruhland felt that many of the hospitals of the state had not fully met their responsibility in regard to contagious diseases among their employees and urged all to protect their staffs by suitable tests and vaccination. He emphasized the important place of social service in the hospital, and advocated teaching centers for nurses in the larger cities where they could secure a standardized academic training, thereafter being apprenticed to hospitals or to field work in public health nursing. Finally, he urged the hospitals of the state to cooperate with the public health authorities in dealing courageously with the venereal disease problem.

In his presidential address Mr. Fritschel reviewed the hospital situation in general in the United States, and specifically in Wisconsin. He stipulated that there were 129 hospitals in the state of Wisconsin having a total bed capacity of 7,570 beds. Of these 129, forty-eight had less than twenty-five beds, twenty-six had between sixty and one hundred beds, while twenty-seven had between 100 and 350 beds. He urged the larger institutions of the state to help the smaller hospitals, which should not, merely because of their size, be looked upon as necessarily inferior in character and type of service.

In his report as executive secretary, Dr. C. W. Munger indicated that the primary aim of the Association during the past year had been to make itself of real value as a service organization to its members, and that its secondary purpose had been to increase its membership. Since the association was organized, the secretary has mailed 7,500 letters, bulletins, and leaflets, visited a number of hospitals, appeared before legislative committees regarding bills affecting hospitals, addressed various hospital staffs and cooperated with the American Hospital Association and the State League of Nurses in favoring desirable legislation.

Following the treasurer's report, which indicated that the Association was in a healthy financial condition, Dr. Munger raised the question of the hospital's responsibility in protecting its employees from contagious disease. He advocated the regular physical examination of all employees, especially those who handle food, and such tests and prophylactic treatment as would protect employees against smallpox, diphtheria, and typhoid fever.

In the absence, because of illness, of Mr. W. T. Williams, editor of the *National Laundry Journal*, Chicago, Mr. H. B. Sherwood of The Permutit Company read Mr. Williams' paper on "The Institutional Laundry—Innovations and Economies."

Mr. Williams touched upon the main points in laundry work. A constant supply of high-pressure steam is necessary in the laundry. The pipes should be of good size, covered entirely with good insulating material. If the washroom does not get its hot water from storage tanks, there must be a steam pipe leading into each washing machine and each machine should have a reliable thermometer attached to make sure that a killing temperature is reached. High-pressure steam is needed for heating the ironing machines, dryrooms and drying tumblers.

Soft Water Very Necessary

Mr. Williams put great emphasis upon the need for soft water for laundry work. The point which is usually brought up by men who are selling water softeners is the saving in soap. This is important, for each grain of hardness per gallon of water causes a loss of 1.6 pounds of soap for each 1,000 gallons of water used. In spite of this there are two more important considerations. The first is the matter of white goods being really white, and not yellow or gray. The goods should also be soft to the touch and not make the patient think that he is lying on fine sandpaper. Second, hard water shortens the life of fab-

Adv. page 42

Treat Hay Fever With Suprarenalin

LABORATORY PRODUCTS

SUPRARENALIN is the remedy in Hay Fever. It may be administered locally, internally or Hypodermatically.

Locally—Solution and ointment are applied to affected parts.

Internally—Solution should be given, so that the patient will get from 1 70 to 1/10 of a grain; the dose repeated in from 10 minutes to 2 hours, according to effects.

(Let the patient hold Suprarenalin in the mouth for awhile, as the best systemic effects are got by absorption through the membranes.)

Hypodermatically—Suprorenalin Solution is injected into the arm or neck.

Suprarenalin is recommended in Hay Fever in various forms. Herewith are suggestions made by men of authority.

One recommends using solutions of varying strengths from 1:10,000 to 1:1000 made up with normal salt solution. To sustain the relief to some extent, he suggests spraying over the constricted mucous membrane a 5 grain to the ounce solution of menthol in albolene, benzoinol or other light oil.

Another uses Suprarenalin Solution in strengths varying from 1:10,000 to 1:1000, applying these locally to the conjunctiva and nasal membranes. He also suggests the following combinations which are snuffed into the nasal passages or insufflated by means of a nasal blower.

1. Suprarenalin ..... 1 part
   Zinc Stearate (Comp.) ..... 100 parts
   Heavy Magnesium Carbonate ..... 900 parts
   Mix. Triturate well.
2. Suprarenalin ..... 1 part
   Zinc Oxide ..... 100 parts
   Bismuth subcarbonate ..... 400 parts
   Mix. Triturate well.
3. Suprarenal gland substance ..... 1 part
   Zinc Stearate ..... 20 parts
   Zinc Oxide ..... 80 parts
   Mix. Triturate well.
4. Suprarenalin ..... 1 part
   Bismuth subcarbonate ..... 300 parts
   Zinc Oxide ..... 300 parts
   Zinc Stearate ..... 200 parts
   Mix. Triturate well.

A prominent nose and throat specialist recommends:

	gm.		
Cocainae hydrochloridi		15 or grs.	iiss
Sodii boratis		30 or grs.	v–
Suprarenalin Sol. (1:1000)	4	or 3	i
Glycerine	2	or 3	ss
Aqua Camphorae ad	30	or	3 i

M. Sig. Use as a spray to the nose four or five times daily or oftener if needed.

Suprarenalin Solution 1:1000 (Armour) is stable, uniform, non-irritating and is free from chemical preservatives. *Literature to Physicians.*

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Page 277

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ries. When hard water is used in the washing machine it is softened by the use of washing soda, and the lime salts in the water are thrown out of solution as carbonate of lime. This, in the form of tiny sharp crystals, remains in the goods and cuts and wears away the fabric.

Sterilizing is a simple process but it should be done carefully, with a good thermometer, for the lives of patients may depend on the degree of care which is taken. Boiling the clothes is not necessary.

Mr. Williams laid stress on buying only the best fabrics, cheap fabrics and fancy weaves do not pay in the end.

Conditions in the laundry should be such that the most efficient work can be done—that is, there should be daylight, and good ventilation to take the heat and the excess humidity out of the air.

Following Mr. Williams' paper, the delegates adjourned to a luncheon, which was served in the auditorium café.

Dr. Herb Advocates Physician Anesthetists

At Wednesday afternoon's session Dr. Isabella Herb, Rush Medical College, Chicago, read a brief paper on "The Anesthesia Problems of the Hospital. She contended that, inasmuch as the administration of anesthetics was a part of medicine, it should be practiced only by regularly licensed physicians. In her judgment, one of the serious lacks in our hospitals is the lack of qualified physicians acting as anesthetics. She feels that the Presbyterian Hospital of Chicago has done a great service in showing how an anesthetic should be administered. She stated that the anesthetist should devote his main time to this work and should be made one of the resident staff, with rank above that of the intern. All matters pertaining to the department of anesthesia should be referred to him, and he should be allowed to use the brand of anesthetic that is most efficient. It is the duty of the anesthetist, she feels, to maintain a high standard of work for the hospital, and this can be done only by using well established methods of administering anesthetics. She called attention to the fact that for years, specially trained anesthetists had been recognized in England, but only recently have they been in America, although many advances in the art must be accredited to America. The services of the anesthetist must be properly recompensed, and should be paid by the patient, thus relieving the hospital of this additional expense. The anesthetist's charges should rest upon the financial status of the patient and the difficulty of the operation.

In discussing this paper, Dr. Munger expressed the belief that it would be difficult to find a sufficient number of physicians who would be willing to devote themselves exclusively to the work, inasmuch as they would not find it sufficiently profitable, except perhaps in the larger medical centers.

In answering some of her opponents' arguments Dr. Herb contended that physicians would be glad to take up the art of anesthesia if properly recompensed for their services; that patients would be glad to pay the anesthetist's bill if the matter was explained to them properly; that many competent physicians are now taking up this special practice; that the fact that you could train a nurse to give an anesthetic does not justify her giving it any more than the fact that you could train the nurse to do a tonsillectomy would justify her doing it; and that an anesthetist must keep in touch with surgical work in order to do his own work intelligently. Mr. Frank E. Chapman, director of the Mount Sinai Hospital, Cleveland, Ohio, stated that the hospital must have trained anesthetists, but that he did not think they needed to be graduate physicians. Moreover, he raised the question as to how a large part of the part-pay and free work would be done under Dr. Herb's plan, and how it would be possible to procure the number of medical men needed to give the necessary anesthetics in Milwaukee.

Following Dr. Herb, Mr. Frank E. Chapman spoke on the advantage of proper hospital accounting.

This is one thing, he said, which has never been given its proper place of importance by hospitals. Unlike business concerns, which spend a large part of their overhead in proper cost and production accounting, hospitals have never taken this sufficiently seriously. The types of accounting which Mr. Chapman outlined are quite similar to those used in business. Most hospital administrators

The delegates of the Wisconsin Hospital Association grouped at one of the entrances of Milwaukee's spacious auditorium.

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Appetite and Digestibility

No appetite means a slow digestion. What does not "make the mouth water" will not make the gastric juices flow easily. Food must be tempting.

Biscuits, muffins, cake, etc., made with

ROYAL Baking Powder

are both delicious and digestible because of their lightness, due to the strong leavening action of the powder.

They are, moreover, healthful because Royal Baking Powder is made from cream of tartar and adds to food the same wholesome qualities that exist in ripe grapes, from which cream of tartar is derived.

Food made with Royal Baking Powder possesses excellent keeping qualities and fine flavor, stimulating to the appetite and digestion as well.

Royal Baking Powder contains no alum

Consult the 1920 Year Book for Catalog information.

have the idea that compiling statistics is the most uninteresting task conceivable; on the other hand, if they would try it they would find it exceedingly interesting. It is important that the compilation be done at once, figures, to be of use, must be up to date. Statistics of the financial performance of the institution should be available within fifteen days after the current month is passed.

The question of medical histories is a much discussed one. The medical history and the analysis of results made therefrom is the production chart of the hospital, and no more careful check could be instituted than an analysis of the medical performance of the institution. Mr. Chapman did not attempt to go into the details of records, as these must be worked out in the individual hospital.

There should be a daily statement of the vital performances of the hospital, no matter how small the institution may be. After each day the statement should be transferred to the record of the month, and then to that of the year. In this way, with the expenditure of very little energy, a complete record of the work done for the year may be kept.

Financial records are sadly muddled in most hospitals. A common practice is to lump all salaries under one heading of "pay-roll." This precludes the possibility of knowing exactly what the expenditure of each department is, which Mr. Chapman believes is a very important matter.

Budget System Best, Says Mr. Chapman

Absolute adherence to the budget system, Mr. Chapman says, is the only way to create a goal for the financial performance of the institution. By a careful keeping of income accounts, the hospital may have a very definite idea of its earning power for the year, and therefore be better able to plan its expenditures.

Each department should have a separate expense account, and should know how much money it is supposed to spend. It is poor policy to try to keep the true figures from department heads. Much better results are obtained if everyone understands the situation, and is pulling for a common end.

In discussing the hospital budget, Mr. H. K. Thurston, superintendent of the Madison General Hospital, pointed out that since the war it was difficult to run the hospital on the budget system because of the difficulty of anticipating expenditures due to rapid changes in prices. He suggested that charts be used in stimulating the interest of boards of trustees in statistical figures pertaining to the hospital.

Mr. Hensen, assistant superintendent, Presbyterian Hospital, Chicago, felt that the departmental expense account is the only one that is satisfactory, but that there was some question as to the extent to which it can be carried out. In the matter of comparing patient day cost, Mr. Chapman stated that it could not be done without at the same time comparing patient day service.

Mr. Perry Swern, of Berlin, Swern, and Randall, read a well thought out paper on hospital architecture, with special attention to interior arrangement.

Hospital Has Many Demands

Mr. Swern began his discussion by outlining the requirements which the hospital must meet. They are: to render the best care to the sick, with as many comforts as possible, and to hasten recovery; to increase the medical and nursing facilities of the community, and usually to provide means for educational and research work; to be so operated that the majority of the community can partake of its services; to be erected and operated on a self-supporting basis which will make it possible to give these and other individual services.

Some of the working facts which must be considered in the planning of the interior, are the conservation of the time and energy of the nursing and medical staff, the efficient and economical distribution of provisions, a flexible arrangement of the facilities, and one which makes possible a maximum bed occupancy, and the use of a simple construction, so that maintenance will be at a minimum.

To meet all these requirements, certain things must be done. First, the nursing radius must be small, to make possible the patients' being close to the nursing station. Duty and service rooms must not be placed in between patients' rooms. Second, the width of the patients' rooms should not be an inch wider than is necessary. Third, the doors, windows, and equipment should be arranged so that every foot of the room serves a purpose. Linen and supply rooms and diet kitchens on the different floors should be eliminated, both for the conservation of space, and for the more efficient running of the hospital.

Advocates Use of Private Room

Mr. Swern strongly advocated the use of the private room, with individual facilities, and believes that they are not more expensive either to build or to maintain.

Mr. Swern also feels that sketches of the hospital should not be made in competition, for the planning of a hospital is too much of a problem to be done without many consultations and a thorough knowledge of the hospital's particular problems. A plan should not be taken over entire from another hospital, for the chances are strongly against the problems of both hospitals being the same. The successful interior arrangement is dependent upon a thorough knowledge of the problem in hand, and the building must be conceived as a whole, in actual operation, before construction work is begun.

The final paper of Wednesday afternoon's session was that of Miss D. M. Kugel, director of home economics, Stout Institute, Menominee, Wis., on the qualifications and training of the hospital dietitian. Miss Kugel stated that the necessary qualifications were good health combined with strength and energy, common sense, good judgment, and conscientiousness. The dietitian, moreover, must be clean, neat, orderly and systematic; she must exercise initiative without being aggressive, and combine resourcefulness with tact; she must be open to suggestion, courteous, and enthusiastic about her work. Since her work is entirely for the benefit of others her watchword must be "service"; she must be a woman who can command the respect of her associates; she must be able to analyze a situation and act on her analysis. In her training she must secure a thorough knowledge of the science of nutrition, the diets of infants and children, the common terminology of disease, the preparation and calculation of special diets, bacteriology and its relation to food; she must also have practice in the use of the microscope and be well versed in the technique and the use of kitchen tools; she must exercise thrift in the use of foods and have some experience in buying. Since she is to teach dietetics to the nurses and others, she must know something about the art of teaching.

On Wednesday evening, some 225 guests gathered in the Fern Room of the Hotel Pfister for an informal banquet. Reverend William T. Dorward acted as toastmaster, and addresses were made by Mr. Frank E. Chapman on "The Hospital Board, Its Privileges and Duties," and by Dr. F. E. Sampson on the Community Hospital.

The early part of Thursday morning's session was de-

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"America's Most Famous Dessert"

AMERICA'S MOST FAMOUS DESSERT
JELL-O
A MIXTURE
SPECIAL PACKAGE
NET WEIGHT 28 OZS
MAKES FOUR QUARTS
RASPBERRY
PURE FRUIT FLAVOR
VEGETABLE COLOR
This package makes four quarts of Jell-O. Serves forty to fifty persons according to size of portion.
Dissolve the contents of the package in four quarts of boiling water and set in a cold place to harden.
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voted to the reports of various committees, including the committee on legislation and the committee on membership. The cities of La Crosse and Eau Clair extended invitations to the Association to hold its next meeting with them. In the absence of Dr. Frederick C. Slobe of the American College of Surgeons, Dr. S. M. Smith addressed the convention on the subject of hospital standardization. He pointed out that the American College of Surgeons wishes to be the friend of the hospitals of the country, and if in its inspections it finds anything wrong, its purpose is to offer constructive criticism. He urged the use of the monthly analysis sheet in the discussion of cases where the preoperative and postoperative diagnostics did not agree.

Care of Child Important

Dr. Smith was followed by Dr. G. E. Ide, medical director of the Muirdale Sanatorium, Wauwautosa, Wis., who spoke on "Occupational Therapy in the Treatment of Tuberculosis." Dr. Ide stated that from 75 to 80 per cent of tuberculous patients are treated in their own homes by family physicians, and that the home should be the place of preliminary training of patients prior to their admission to the sanatorium. He also made the point that if children between the ages of four and fourteen are properly taken care of in regard to developing the heart and muscular system they will carry immunity from tuberculosis through life. The remainder of Thursday morning's session was devoted to a round table discussion led by Mr. Asa S. Bacon, superintendent of the Presbyterian Hospital, Chicago. Mr. Bacon was assisted by: Miss Amalia Olson, R.N.; Dr. S. M. Smith, Miss Hannah Paulson, R.N.; Sister M. Seraphia; Dr. J. K. Goodrich; Dr. J. N. Bauernfriend; Mr. H. K. Thurston; Miss Schoolbred, R.N.; Mrs. G. A. Hipke; Miss Agnes Reid, R.N.; Dr. J. W. Coon; and Miss Ella B. Smith, R.N.

In opening the round table discussion, Mr. Bacon made the following introductory remarks: "The evolution of hospitals in America from pioneer days, and during a period of one hundred and fifty years, is very interesting; indeed. We do not have to go back any farther than the Civil War and compare the handling of the sick and wounded at that time with our late World War.

"Hospitals were originally established to care for the insane and the homeless poor, while today they are inhabited by all classes, who are treated for all ills known to man. At the same time they have become one of the greatest factors in the health of the people as a whole.

"Hospitals of the present are not only institutions for the sick, but they are educational, turning out thousands of students in medicine (interns), nurses, dietitians, social service workers and others, as well as holding dispensaries and clinics for the education of the public. All of which means that a hospital has to be an organization highly developed for service. In order to meet the demands this evolution has brought about, various societies have sprung up, among which the American Hospital Association is foremost. State associations are organizing, and with our two hospital magazines, medical and others journals, and various organizations dealing with the health of our people, an educational opportunity is afforded to hospital superintendents such as they have never had before.

"We often hear that hospitals are more poorly managed than any other business, but in looking over Dun's or Bradstreet's reports we see a very large percentage of business failures, while there are very few hospitals that actually close their doors. This in spite of the fact that during the World War hospitals in this country increased their rates on an average of only 35 per cent. They have never been accused of profiteering. They weathered the storm in spite of the fact that they sent thousands of their trained people to care for our sick and injured soldier boys.

"These hospital superintendents who stayed at home and stuck to their jobs received no recognition, nor did they ask any. As this is the reconstruction period, I feel that it is the proper time to be a little more considerate in our criticism of the way some of our superintendents run their hospitals, and to do all we can to assist them in their complex problems. It is to this end that we have developed the American Hospital Association to its high standard of efficiency, the Wisconsin Hospital Association, and other organizations. It is for this purpose that we hold gatherings such as this today, to try to work out means for more economical and better care of the sick, and I trust you will all take an active part in the discussions."

Who Directs Hospital Policy

The first question discussed was as to what extent the medical staff should have authority to direct the general policy of the hospital. It was felt that the medical staff might properly make recommendations, but that they have no authority to direct the hospital's policy. In discussing this question, however, Dr. A. R. Warner said there was a distinct trend among the better physicians to take more interest in the hospital, and that hospital administrators must meet them half way. He therefore urged hospital executives to seek the cooperation of the physicians in matters pertaining to legislation. In discussing the matter of the attendance of the superintendent of the hospital at staff meetings, it was brought out that a number of the hospital superintendents present at the convention were in the habit of attending these meetings as well as meetings of the board of managers.

What is the Ratio of Patients and Interns

The question was raised of a reasonable ratio of patients to interns. Mr. Chapman held that this ratio depended on the kind of service interns were required to render. Someone suggested an average of one intern to every thirty-five patients. Dr. Munger felt that this ratio was too high, especially if the intern is required to make the case records. He felt that the ratio should be one to eighteen, or preferably one to fifteen. In discussing whether separate charges should be made for each service rendered by the laboratory, it was pointed out that some hospitals make a special charge for Wassermanns, spinal fluid, and other special tests, and that for the routine laboratory work some hospitals make a charge from $2.00 to $5.00. The question was raised as to whether a special budget should be advocated for the training school for nurses. Dr. Warner felt that this question represented the half expressed idea of those who favored taking the training school out of the hospital and making it a part of university education.

Suggestions were asked as to how to reduce the hospital's printing bill. One teaching hospital has reduced its bills by installing its own printing department. Mr. Chapman felt that the indiscriminate ordering of forms had much to do with the large bills. Another delegate said the elimination of the red lines from various forms resulted in a considerable saving. It was suggested that both sides of the historical sheets and of the nurses' records be used.

During the discussion of the question as to what charges should be made for compensation cases, a resolution was passed endorsing the principal of cost for service and re-

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(Small, Medium, Large sizes)

No. 28 Pepperell Cloth, double yoke front; wide hems and tapes in back; open all way down. 36 in. long, long sleeves—per dozen, now..... $13.50

No. 128 Indian Head. Same style as No. 28—per dozen, now..... 13.50

No. 228 Fruit of the Loom Muslin, same style as No. 28. Per dozen, now..... 13.50

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No. 475 White Duretta Cloth. Price, per dozen, now..... 36.00

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referring the question to the board of trustees for action. Dr. Warner indicated that industrial establishments want good results and that they therefore want the best medical service obtainable and are willing to pay for it. He also said that the state should meet its responsibility in industrial cases. In discussing the question as to whether osteopaths should be allowed to treat patients in general hospitals, it was pointed out that there is a growing tendency to make hospitals finally responsible for the special work done within their walls, and that therefore osteopaths should not be allowed to treat patients in general hospitals unless the patients sign a document releasing the hospital from all responsibility for the harm that might be done by the osteopathic treatment. It was pointed out that at the Presbyterian Hospital of Chicago, an osteopath may bring his case to the hospital by placing the patient under the supervision of one of the hospital's attending physicians.

In a discussion of the follow-up of patients, it was brought out that such a system depended on the character of the hospital's work. Thirty percent of the patients of the Presbyterian Hospital of Chicago, for example, come from out of town, and these patients obviously could not be asked to return to the hospital for a follow-up visit. The question of how long patients' records should be kept on file was discussed. Some of the hospitals have kept their records since the hospital was started, but usually records that are older than five years are put in permanent storage. In discussing the subject as to how hospitals can best collect old accounts, Mr. Bacon suggested that, so far as possible, charges should be collected in advance. He pointed out that the bills of the Presbyterian Hospital of Chicago indicate that all bills must be paid weekly and that all accounts must be settled before the patient leaves the hospital.

In his paper on "The Medical and Hospital Program of the University of Wisconsin," read Thursday afternoon, Dr. C. R. Bardeen, dean, Department of Medicine, University of Wisconsin, pointed out that one of the principal features of this program was the active cooperation between the central hospital, to be built at Madison, Wis., and the other hospitals scattered about the state.

Miss Parsons Discusses Nursing Problems

Miss Sara E. Parsons, former superintendent of nurses, Massachusetts General Hospital, Boston, spoke on standards for schools of nursing. She stated that it was the growing consensus of opinion of those who were studying the nursing situation in this country, that it was necessary to adopt a shorter course of study than had hitherto prevailed, during which intensive courses in general medicine, surgery, obstetrics, and pediatrics would be given. This, she intimated, was a hard conclusion to arrive at for those who thought other branches should be included. Miss Parsons expressed the conviction that the nursing problem will not be solved in this country until the various states pass protective legislation, under which it will be illegal for anyone to give professional care to the sick unless he or she is licensed as a trained nurse or a trained attendant. The present situation presents two fundamental difficulties: lack of money, and the instability of training schools due to frequent changes in the personnel. She called attention to the present tendency of affiliating nursing schools with universities and of taking preliminary courses in theory at the junior colleges. One of the present necessities of the day in Miss Parsons' judgment is the education of the public regarding hospitals and schools of nursing, a most difficult task but one which must be accomplished.

In discussing Miss Parsons' address, Miss Carol L. Martin of Chicago enumerated some of the reactions and prejudices of the public toward the work of nursing. Parents object to the hours of work and the home and social life of the students, the girls themselves feel cut off from normal social life, and educators object to the inferior educational methods of the majority of the nursing schools.

Miss Marion Rottmann of Milwaukee, Wis., took occasion to outline a bill which was recently introduced in the Wisconsin State Legislature and which was designed to place nursing in Wisconsin on a higher plane. Among other things the bill provides for a minimum two-year course of training with one year of high school as a preliminary and compulsory legislation.

Mr. John E. Ransom, superintendent of the Michael Reese Dispensary, Chicago, read a paper on "The Significance of the Dispensary" (to be published in a later issue of THE MODERN HOSPITAL).

The concluding address of the convention was delivered by Miss Edith J. Habbe, director of social service, Milwaukee Children's Hospital, Milwaukee. She spoke on "What is Social Service," stating that its biggest feature was "case work," in which an effort was made to aid the doctor in diagnosis and in helping him to carry out the treatment prescribed. In discussing this address, Mr. John E. Ransom expressed his conviction that the object of social service was to make the good which the medical institution does or can do, secure and effective for the patient and the community.

The officers of the Association were reelected: President, Rev. H. L. Fritschel, superintendent of Milwaukee (Passavant) Hospital, Milwaukee; first vice-president, Mr. H. K. Thurston, business manager, Madison General Hospital, Madison; second vice-president, Miss Joan Mutschmann, R.N., superintendent, La Cross Lutheran Hospital, La Crosse; treasurer, Dr. C. W. Munger, superintendent, Columbia Hospital, Milwaukee.

BRITISH COLUMBIA ASSOCIATION ISSUES TENTATIVE PROGRAM

The British Columbia Hospital Association is meeting at Kamloops, B. C., July 6, 7, and 8, 1921. The tentative program, which follows, indicates that the Association is adopting a new idea in having fewer papers, and getting down to the immediate problems which are common to all its members. In this way a maximum time will be possible for discussion, both through open forum and question drawers.

TENTATIVE PROGRAM OF THE B. C. HOSPITAL ASSOCIATION CONVENTION

Kamloops, B. C., July 6, 7, and 8, 1921

July 6, 1921—Nursing

Morning Session, 10:00 A. M. to 12:00 Noon—Miss E. I. Johns, R.N., Presiding

Reports of Committees.

Nursing Care of Tuberculous Patients in British Columbia.

Round Table—A: Training School Problems

(a) Report on questionnaire submitted during current year.
(b) Living conditions for staff nurses and pupils in the hospitals of British Columbia.
(c) Traveling instructors.
(d) Question box.

Round Table—B: Registration

Examination and registration of nurses in British Columbia from a hospital point of view.

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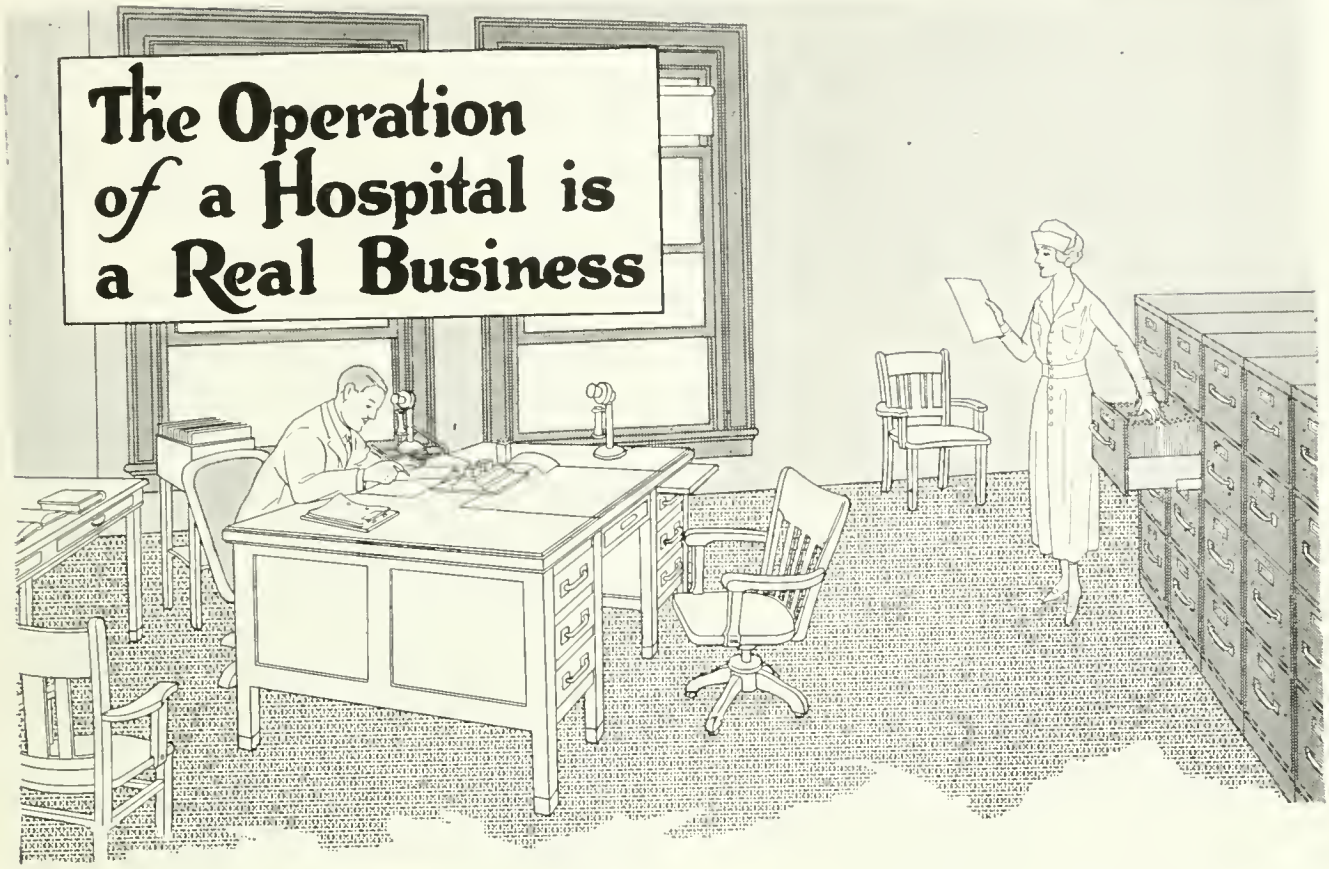
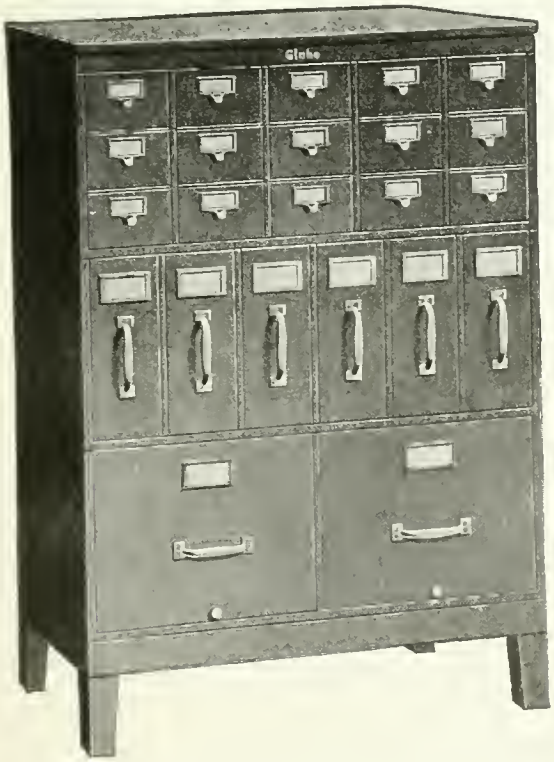
The Operation of a Hospital is a Real Business





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NEW ORLEANS

Afternoon Session, 2:00 to 4:30 P. M.—Miss E. I. Johns, R.N., Presiding

Round Table—C:

(a) Discussion of plans whereby the various schools of the Province can be brought more closely into touch so as to promote unity and mutual understanding.
One plan suggested is as follows:
An annual institute meeting of superintendents and instructors of nursing. Lectures and demonstrations planned to meet the needs of training school administrators and teachers would be given. The duration of such an institute might vary from a few days to two weeks.

(b) Question box.

Evening Session, 8:00 to 10:00 P. M.—Public Meeting, H. C. Wrinch, M.D., President, Presiding

Addresses of Welcome:
Mayor of Kamloops, for city of Kamloops.
J. T. Robinson, chairman of board of directors, Royal Inland Hospital, Kamloops, for hospitals.
W. H. Irving, M.D., president Medical Association of Kamloops, for the medical profession.

Response to addresses of welcome, by M. C. Wrinch, M.D., Hazelton, B. C., president of the B. C. Hospital Association.

Address—Health Tax.

Address—Hospital Tax.

July 7, 1921—Medical

Morning Session, 10:00 A. M. to 12:00 Noon—H. C. Wrinch, M.D., President, Presiding

Paper—The Hospital and the Medical Staff.

Paper—Medical Records in Our Hospitals.

Paper—Laboratory Service in Hospitals.

Afternoon Session, 2:00 to 4:30 P. M.—G. S. Purvis, M.D., Presiding

(a) Discussion of papers of previous section.

(b) Open forum,
(1) Anesthesia,
(2) Infections,
(3) Tuberculosis.

(c) Question drawer.

Evening Session, 8:00 to 10:00 P. M.—Public Meeting, H. C. Wrinch, M.D., President, Presiding

Address—Hospital Standardization.

Address—Hospital Service in the Industrial North, illustrated.

July 8, 1921—Business

Morning Session, 10:00 to 12:00 Noon—H. C. Wrinch, M.D., President, Presiding

Paper—The Present inadequate Method of Financing Hospitals.

Paper—Hospital and Contract Work.

Paper—The Workmen's Compensation Act and Our Hospitals.

Afternoon Session, 2:00 to 4:30 P. M.—E. S. Withers Presiding

(a) Discussion of previous session papers.

(b) Report of Committee on Accounting.

(c) Open forum,
(1) Purchasing,
(2) Collections.
(3) Economies.

(d) Question Drawer.

Evening Session—Entertainment.

CONNECTICUT ASSOCIATION ELECTS DR. H. W. HERSEY PRESIDENT

The second annual meeting of the Connecticut Hospital Association was held at the Hotel Winthrop, Meriden, Connecticut, on Wednesday, June 1, 1921, at 2:30 P.M. Reports of the various committees were received, including a report on the work of the Association during the past year by its president, Dr. L. A. Sexton, superintendent Hartford Hospital.

Following these reports, Dr. Harold W. Hersey, superintendent New Haven Hospital, spoke on "The Objects of a National Hospital Day" and gave a report of its celebration in the state of Connecticut. The principal address of the afternoon was delivered by Dr. J. F. Bresnaham on "The Hospital as a Community Asset." The following officers were elected for the coming year: President, Dr. H. W. Hersey, superintendent New Haven Hospital; first vice-president, Mr. F. Leon Hutchins, superintendent W. W. Backus Hospital, Norwich; second vice-president, Sister Alice, superintendent St. Vincent Hospital, Bridgeport; secretary, Miss K. M. Prindiville, superintendent Lawrence and Memorial Associated Hospital, New London; treasurer, Miss J. Allison Hunter, superintendent, Grace Hospital, New Haven; executive committee, William Bro. Smith, director, St. Francis Hospital, Hartford; Dr. L. A. Sexton, superintendent, Hartford Hospital; and Miss Evelyn M. Wilson, superintendent Stamford Hospital.

Dr. H. W. Hersey, newly elected president of the Connecticut Hospital Association, is a graduate of Harvard University and Harvard Medical School. Prior to his appointment as superintendent of the New Haven Hospital in September, 1919, Dr. Hersey was first assistant resident physician of the Massachusetts General Hospital.

The almshouse and infirmary of Blackwood, N. J., is planning a $40,000 addition.

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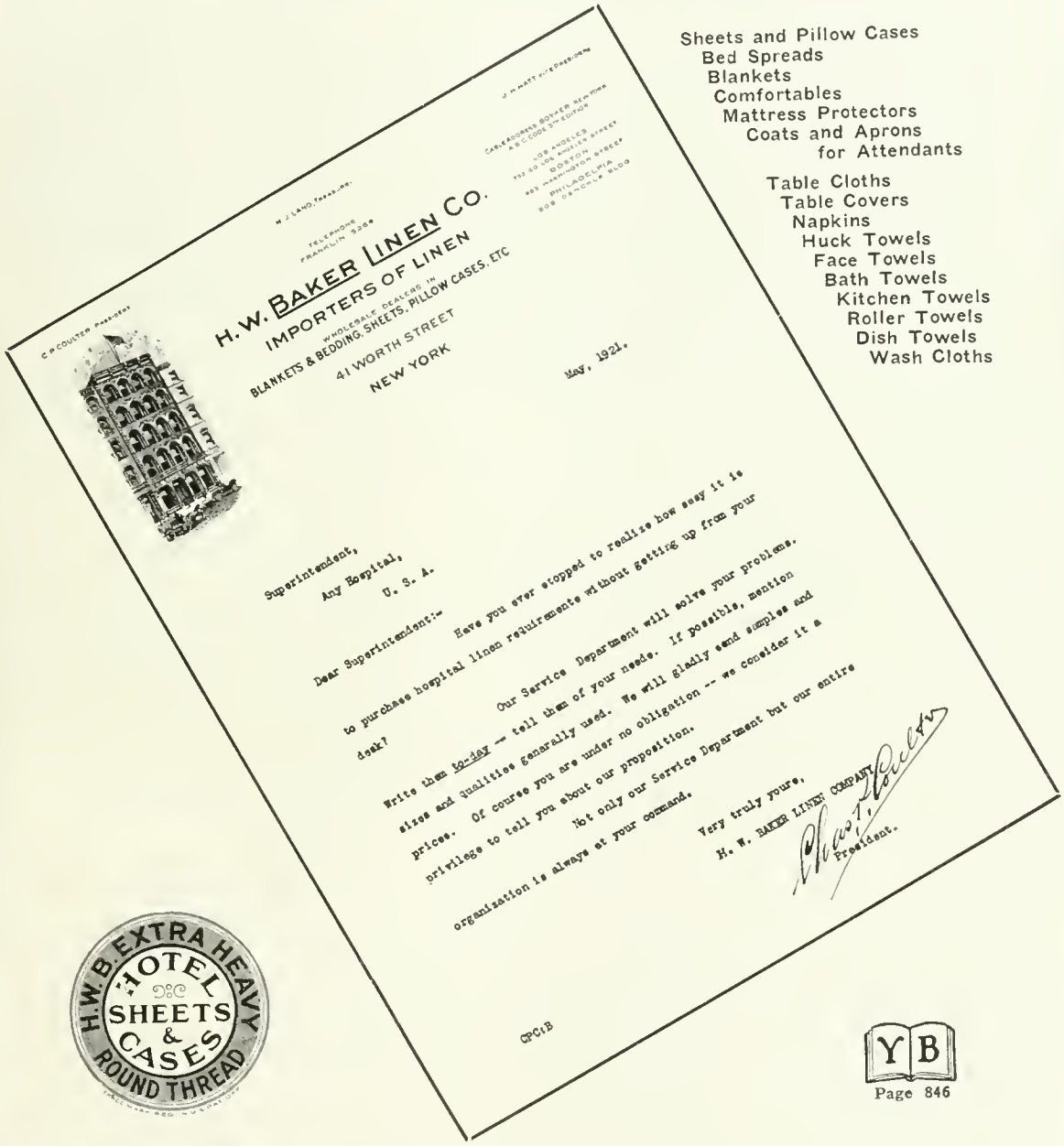
AN OPEN LETTER—
To Superintendents of Hospitals and Allied Institutions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MICHIGAN HOSPITAL ASSOCIATION MEETS AT STATE UNIVERSITY

A BETTER understanding between the representatives of hospitals of the State and the development of a community of interest among hospitals through co-operation, were stipulated as two of the important functions of State hospital associations by Dr. Christopher G. Parnall, president of the Michigan Hospital Association, in his informal opening words at the fourth annual meeting of the association at Ann Arbor, Tuesday afternoon, June 7, which was attended by representatives of 30 different hospitals throughout the State. The co-operation of the hospitals with the nursing organization in the State showed that the hospitals could recognize their common needs. Speaking of the community aspects of the hospitals, Dr. Parnall felt that the public was fast being informed of the hospitals and their work and that it would not be long before they would have greater support from the public. He indicated that the Association has been especially active along legislative lines during the past six months, promoting desirable, and blocking harmful, legislation.

More Hospitals Needed

Speaking on the subject of "The Hospital and the World's Life," the Rev. W. M. Puffer, trustee of the Bronson Hospital, Kalamazoo, reviewed certain figures indicating the amount of sickness in this country, the number of existing hospital beds and the number that should be supplied in order to give the sick adequate institutional care. He pointed out that, with the growth of cities, more and more hospital beds would be needed, particularly for the care of industrial accidents and disease. He quoted figures showing that there were 30,000,000 wage earners in this country who lost an average of nine days every year on account of illness. This represents an economical loss of $500,000,000 to which must be added an additional $500,000,000 for medical and nursing care, making a total annual cost of a billion dollars. This, Dr. Puffer said, was twice the amount given annually to philanthropic activities in this country. Dr. Puffer made a special plea for more children's hospitals. He indicated moreover, that the hospital affords one of the best opportunities to promote useful American citizenship among the foreign born.

Dr. Cabot Warns Against Psychic Damage

The avoidance of psychic damage in the care of hospital patients was the theme of a very stimulating address by Dr. Hugh Cabot, professor of surgery, University of Michigan. Dr. Cabot called attention to the striking development in the hospital field during the last century and stated that many were beginning to believe that the hospital is the only place in which to be seriously ill or to have a major operation. Up to the present, Dr. Cabot, pointed out, hospital construction was governed largely by a desire to deal effectively with the ills of the body and to avoid infections. We have behaved as though the patient had a body but no mind or soul. During his residence in the hospital the patient is in an environment that is new and strange and, if he is not seriously ill, he will spend his time gaining impressions which, like the half truths of epigrams are more dangerous than lies. Hospitals do not take enough trouble to see that patients do not get wrong impressions. In this connection, he thought that patients might very readily be divided by hospital authorities into those who are not obviously suggestible and those that are. During his war experience Dr. Cabot saw many suggestible persons who were mimicing the real tragedies.

Dr. Cabot feels that every hospital has a spiritual atmosphere which should be guided by its administrative authorities and medical staff but he fears that, because of the great interest in medical efficiency, this has frequently been overlooked and surgeons were more to blame for this than anyone else in that they do not stage their operations in such a way as to recognize their seriousness to the patients. He made a plea that the impressions of a patient in a hospital, particularly the surgical patient, be made as nearly negative as possible. He would have them slip in a side door, be freed from hospital noises and smells, and have a sound sleep the night before the operation, induced artifically if necessary.

While the permanent psychic damage to many is insignificant, to a minority it is very damaging. They carry the faulty suggestion with them through life. When convalescence begins, it is often necessary to transfer the patient to larger quarters where there are others having illnesses which they are unable to judge and weigh in the balance.

Open Ward Losing Favor

From the standpoint of psychic insult, it would be hard to defend an open ward. Dr. Cabot pointed out that the whole tendency now is to get away from the open ward and that if there were no other reasons, the grave danger of psychic insult would condemn it. If damage has been done to one per cent which could be avoided, this would be regarded as a bad record clinically. Dr. Cabot thought that something might be done in the progress of hospital construction to avoid having the patient come into direct contact with tragedy and that the cost of such construction would be justified by the results.

Standards for the Small Hospital

Following Dr. Cabot's address, the Rev. Father Michael P. Bourke, superintendent of Catholic Hospitals in Eastern Michigan, read a paper on "Standardization from the Standpoint of the Small Hospital." He stated that this subject involved only one question and that an important one: Is not life as precious in small rural communities as in the large urban centers. He defined the small hospital as a hospital of 25 beds or less and standardization as the process whereby hospitals are elevated to a level where they can give the best care commensurate with their facilities. One of the first requirements for the standardization of a small hospital is a competent, well organized, and honest medical staff, on which no man should be a member who is not big enough to consult with his fellow staff members. There should be periodical staff meetings, which are a boon, especially to the younger men. In the second place, there should be accurate and complete case records of every patient. The small hospital cannot exempt itself from these requirements as every doctor must stand on his own records. These are important, moreover, for legal purposes. Only enough record was necessary Father Bourke felt to help the

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hospital keep a perfect check on its activities. In the third place, the small hospital must have well equipped laboratories so that every precaution can be taken to rob surgery of many of its terrors.

The final address of the Tuesday afternoon's session was a discussion of the "Problems of the Small Hospital," by Miss Josephine Halverson, superintendent of the Port Huron Hospital.

Committee on Legislation Reports

The Association's committee on legislation indicated in its report that the Association had interested itself in three bills. One bill protects the hospitals of the State in the same manner that the hotels are protected. It opposed the bill which deprived closed hospitals of their freedom from taxation and supported a bill amending the present nursing law. This latter bill, amended the nursing law in ten points: (1) it increases the preliminary educational requirements for the registered nurse from the eighth grade to two years of high school. Under the present law Michigan cannot establish reciprocal relations with other states and nurses may not be registered in other states on the basis of their Michigan certificates as Michigan requirements are too low; (2) it reduces the terms of members of the state board from six to four years and changes the time of appointment to conform to the opening of each legislature; (3) it permits recognition of nurse certificates as secured in foreign countries; (4) it raises the fee for examination from ten to fifteen dollars; (5) it permits the issuance of temporary certificates in cases of emergency, the state board to determine the necessity therefor; (6) it states more clearly some points of the original bill with regard to the expenses of the state board; (7) it makes the term "Registered Nurse" the official designation and inclusive of "Trained," "Certified," "Graduate," or "Registered" nurses; (8) it defines the term "Registered Nurse"; (9) it provides for annual renewal of certificates; (10) it provides for what are called "Trained Attendants."

Mr. Chapman Tells About Cleveland Survey

The second session of the convention was held on Tuesday evening in the Pattengill Auditorium. The formal addresses of the evening were preceded by a brief musical program rendered by the students of the University School of Music. Mr. Frank E. Chapman, director of Mount Sinai Hospital, Cleveland, Ohio, spoke on the results of the Cleveland Hospital Survey. He reviewed the social structure of Cleveland, dwelling particularly upon the Jewish Federation of Charities, the Cleveland War Chest and the Cleveland Hospital Council, to the latter of which twenty-two Cleveland hospitals reported the statistical details of their daily performances. He said that the Cleveland Hospital Survey had resulted in the awakening of the public to their responsibilities in matters of public health and in the establishment of a Public Health Council which employed a full time secretary to keep in touch with the health and social welfare of the city. Because of the interest stimulated by the survey a bureau had been established for the dissemination of hygiene among school children, an effective Jewish Children Placing agency had been organized and the Visiting Nurses' Association has been doing a bigger work than it had ever done.

A $3,500,000 bond issue had been passed which will provide the city with 950 additional beds. These, it is thought, will be ready in another five or six months. The Survey revolutionized the administrative policy of one large four hundred-bed hospital and had awakened the city to the necessity of more dispensary facilities. The hospitals of Cleveland are shortly to establish a central bureau for the collection of accounts and also a central gauze and sewing room. The question of the purchase of many drugs and the manufacture of other drugs through co-operation with Western Reserve University is also receiving serious consideration as is also the establishment of an orthopedic center with a central brace shop to do the work needed for crippled children.

Delegates Hear President of University

The closing address of the evening was delivered by Dr. Marion L. Burton, president of the University of Michigan, in which he emphasized the needs of the University, especially the need of additional funds to complete the construction of the University Hospital.

Wednesday morning's session was devoted to a discussion of "The Need for Hospitals for Communicable Diseases," by Dr. W. J. V. Deacon, Epidemiologist, Michigan State Department of Health, and a "Round Table Discussion," led by Dr. W. L. Babcock, superintendent of Grace Hospital, Detroit. Dr. Deacon pointed out that in contagious diseases, persons rather than things are to be feared and that the principle of quarantine cannot be as yet abandoned as people cannot be trusted to care for themselves properly. The old idea of the pest house is no longer to be tolerated. Small communities cannot be expected to erect and maintain contagious disease hospitals and he could see no reason why a general hospital could not be so constructed so as to take care of contagious disease cases in appropriate wards. For the present Dr. Deacon favors the plan of a contagious disease ward without any direct connection with the rest of the general hospital. He pointed out that the use of the hospitals for the care of contagious diseases was more advanced in England than here. The presence of facilities for the care of contagious diseases is a definite economic value to any community. Certain diseases, moreover, especially typhoid fever, can only be controlled by hospitalization since members of the household can not be depended upon for proper control.

In discussing Dr. Deacon's paper, Dr. A. R. Warner pointed out that the trustees of the Association had officially recommended to hospitals that they admit persons suffering with tuberculosis and that the trustees had also adopted a resolution recommending the admittance of venereal diseases to general hospitals and plainly labeling them as such. Dr. Parnall indicated that the care of communicable diseases is largely a matter of technique [illegible] medical care in general was much the same as the [illegible] given other diseases and the differences in most hos[illegible]s that they are not organized to take care of [illegible]icable diseases and are so crowded as not to be prepared to carry out the necessary technique. He feels that the time is not far distant when every hospital will have a communicable disease department.

Small Hospitals Advised to Affiliate

In discussing the opening question submitted to the Round Table on the future management of small hospitals, Dr. A. R. Warner said that the biggest question before the American Hospital Association and the hospital field is how to get into the small hospital that which is developed in the experimental hospitals, such as teaching hospitals which have extensive laboratories and university facilities. Dr. Warner could see no reason why there should be any difference in the quality of the services rendered by both the small and the large hospital. Mr. Springer held that the ultimate outcome of the nursing

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school in small hospitals would be analogous to the situation now existing between some of the small colleges and universities; that is, adjustments would be made more and more between small hospitals and large hospitals which would furnish practical experience along lines which the small hospitals could not supply.

Vaccination of Nurses Urged

In reply to the question as to whether a nurse should be permitted to care for a typhoid fever patient without first having been vaccinated, Dr. Deacon, Epidemiologist, Michigan Department of Health, said that vaccination should be insisted upon. He stated that the enormous advantage of immunization was established by experience in the Mexican and World War. The World War experience thus far indicates that typhoid immunity lasts from three to four years. In discussing the question as to how best to handle the intern problem, in the 30-bed hospital, it was pointed out that the fifth or interne year of medical education was being rapidly established and would soon be universal. This service will be supervised by the medical schools and will no longer be placed on a monetary basis. Most men, it was indicated, now choose their internship on the basis of its educational value. In all probability, small hospitals will have to employ nurses especially trained in laboratory and microscopic work as substitutes for internes. In view of the growth of the fifth year interne movement, hospitals were urged to place their interne services on a basis which will enable them to meet the requirements.

In answer to the question as to how often the executive committee of the medical staff was to meet, it was stated that regular meetings should be held once a month and special meetings when necessary. Moreover, the superintendent should meet with the executive committee and also with the board of trustees.

Hospital Charges Vary in State

In the discussion of reasonable rates for ward patients and compensation cases, it was evident that no uniform charges were made by the hospitals in Michigan. Three hospitals in Grand Rapids have an agreement under which they charge $4.00 per day for compensation cases and another hospital charges $3.00 for compensation cases and $2.50 for general ward patients. The Hackley Hospital charges those occupying a bed in one of their twelve bed wards $2.50 a day, those who occupy a bed in a smaller ward $3.00, and those in private rooms from $4.50 to $6.00 per day. Dr. Parnall feels that in endowed institutions a cost rate should be established for county, city, and insurance company cases, and then give special rates in special cases, depending upon the patient's ability to pay. It was pointed out that in Ohio all industrial cases are paid for by the state on a basis of cost for service.

Delegates Visit New University Hospital

Wednesday afternoon a number of the delegates took occasion to visit the new University Hospital under the guidance of Dr. Parnall, its medical director.

The following officers were elected: President, Dr. Merrill Wells, superintendent Blodgett Memorial Hospital, Grand Rapids; vice-president, Miss Lydia Thompson, R.N., superintendent Saginaw Women's Hospital; Miss Carrie L. Eggert, superintendent of Women's Hospital and Infant's Home, Detroit; and Miss Josephine Halverson, superintendent Port Huron Hospital, Port Huron; Secretary Mr. Durand W. Springer, superintendent University Homeopathic Hospital, Ann Arbor; treasurer, Dr. Herman Ostrander, superintendent Kalamazoo State Hospital, Kalamazoo, Michigan; trustees, to fill vacancies that occurred this year, Dr. Warren L. Babcock and Dr. Christopher G. Parnall.

The next meeting of this Association will be held on December 6 and 7 at Flint, Michigan.

MORE CHILDREN DIE FROM ACCIDENT THAN DISEASE

Statistics which have been compiled by the American Red Cross show that 20,000 children less than fourteen years of age lose their lives in accidents every year. One hundred and sixty-seven out of every 1,000 child deaths, between the ages of five and nine, are due to accidents, 177 out of every 1,000 deaths between the ages of ten and fourteen. In 1917 there were more deaths from accident than from epidemic disease, the former having a percentage of 17.7, the latter 17.1.

Seventh Annual Convention of the Ohio Hospital Association, Cleveland, Ohio, May 16-20, 1921. (See the June issue of THE MODERN HOSPITAL, pp. 556-559 for an account of the meeting.)

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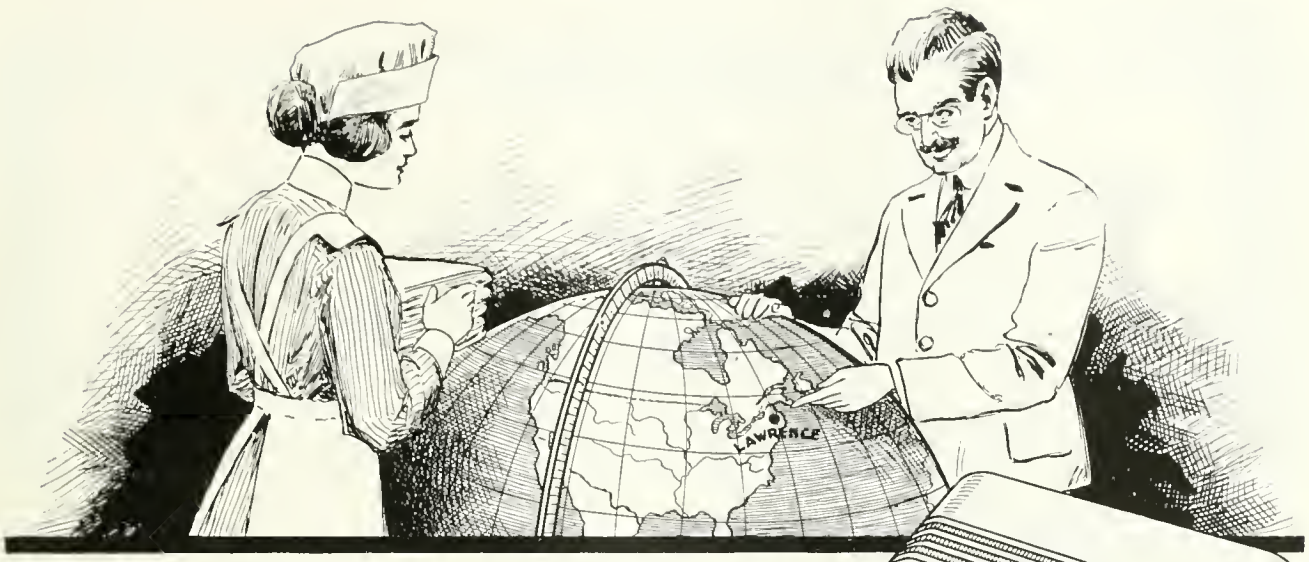

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Book Reviews and Current Hospital Literature

SANITATION FOR PUBLIC HEALTH NURSES

(The Fundamentals of Public Health). By Hibbert Winslow Hill, M.B., M.D., D.P.H. Late Director, Division of Epidemiology, Minnesota State Board of Health; M. O. H. of London, Canada; and professor of public health, Western University; now executive secretary, Minnesota Public Health Association. Author of "The New Public Health."[1]

Since Public Health work is receiving so much attention of late it is highly desirable that reliable information be given in a form which may be understood by one not familiar with technical terms. Dr. Hill has met this need very well. Though the book was written primarily for public health nurses, it will be found helpful to one who is teaching subjects relating to sanitation as well as to one who is doing practical work in sanitation and public health.

The relation of hygiene and sanitation to the prevention of disease and promotion of health is discussed briefly in the first chapters, but in a way which offers a foundation for the other material. Communicable diseases are treated more in detail, attention being given to the commonly prevalent forms. Recent theories in regard to these diseases are included in the directions for treating them.

Since nutrition is so fundamental a part of health, it is to be regretted that this subject was not taken up more specifically. That Dr. Hill realizes the importance of this subject is shown in the following statement which he makes: "The bulk of the race is, even today, far from having complete knowledge of the principles of proper feeding and even farther from consistent practice of them."

There is a chapter on Food and one on Water but the definite relation between nutrition and health deserves greater emphasis.

The nurse, the dietitian, the teacher, the extension school worker, and the home-maker will all find this book helpful.

TEXT BOOK OF CHEMISTRY FOR NURSES AND STUDENTS OF HOME ECONOMICS

By Anna Louise Macleod, Associate Professor of Chemistry, Vassar College; Assistant Professor, Nurses' Training Camp; Lecturer in Chemistry, Vassar Brothers Hospital, Poughkeepsie, 1918-1919.[2]

It is a genuine pleasure to note the addition of this new textbook on chemistry, for the number of similar texts is limited and the need for a satisfactory one is great. Without question Miss MacLeod's contribution is valuable and will prove helpful. Great wisdom has been shown in the selection of subject matter, and in the application of chemical principles to phenomena that come within the experience of the nurse and the student of home economics.

It is however a matter of regret that it was felt necessary to make so great a concession to existing limitations as the failure to emphasize the *absolute neccssity* for laboratory teaching. Among science teachers there is general agreement that the only worth-while method of teaching chemistry is the laboratory method; and by this is meant not only demonstrations by the teacher, but actual experimental work by the students.

It is true that suitable laboratories are rarely found in nursing schools, and the need for adequate instruction in chemistry is not recognized in many of these schools; but this only makes the necessity for definite emphasis on the correct method of teaching greater than if the conditions were otherwise.

We hope that an allotment of thirty-three pages to laboratory directions out of a total of 176 will not convey an erroneous impression which we are sure is contrary to the author's convictions.

X-RAY OBSERVATIONS FOR FOREIGN BODIES AND THEIR LOCALISATION

By Captain Harold C. Gage, A. R. C., O. I. P. 83 pages.[3]

The mastery of this volume will enable any roentgenologist accurately to localize foreign bodies and will materially assist any surgeon in the extraction of foreign bodies. The writer of the book did excellent work in an American Red Cross Hospital during the entire period of the war, both in forward and in base hospitals. The methors described, as is true of nearly all the methods brought forward during the war, are not original with the author; but have been described, in principle at least, since the earliest days of roentgenology.

Stress is laid upon the simple fluoroscopic methods and these are far more satisfactory than the complicated plate methods which are more expensive as well as more time consuming. The author's favorite method is by three intersecting lines. This principle of intersecting lines was first described by Morize in 1898. Mr. Gage made numerous ingenious adaptations of this method which facilitated its employment. In fact, this book is full of numerous ingenious suggestions and devices which we owe to the author. A number of mechanical devices such as the Hirtz compass are referred to, but not described in detail. A copy of this work should be placed in every x-ray laboratory. It is gratifying to note the author's appreciation of the work of Dr. Beclere, the dean of French Radiologists, who has endeared himself to every American with whom he has come in contact.

1. The MacMillan Co., New York.
2. McGraw Hill Book Co., Inc., New York.
3. C. V. Mosby and Co., St. Louis, Mo.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XVII *August 1921* No. 2

THE HOSPITAL OF THE TENNESSEE COAL, IRON AND RAILROAD COMPANY

By GUSTAVE W. DRACH, Architect, Cincinnati, Ohio

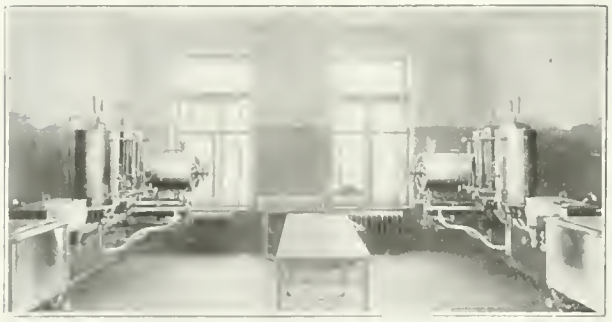
THE hospital of the Tennessee Coal, Iron and Railroad Company, at Fairfield, Ala., is probably the most ambitious industrial hospital attempted up to the present time. It is for the care and treatment of the employees and their dependent families of the Tennessee Coal, Iron and Railroad Company, a subsidiary of the Steel Corporation, and is known as the Employees' Hospital, Fairfield. It has a capacity of three hundred and twenty-five beds and cost one and one-half million dollars complete, including equipment.

The site selected for the hospital is on a hill at an elevation of about one hundred and fifty feet above Fairfield, approximately six miles outside of Birmingham. The grounds around the hospital, and the slopes of the hills, are covered with dense forests, making it an ideal location for an institution of this kind.

The buildings are placed on a plateau having a gentle slope in every direction. The front is on the highest level, the basement set well out of ground, leaving the basement floor level with the ground in the rear, and the floor of the laundry entirely out of ground. The approach to the buildings is by means of a winding roadway skirting the hill around the power house to the front of the building. The main building consists of a central hall containing the stairs and elevators, with four wings radiating from this central hall.

The General Hospital of the Tennessee Coal, Iron and Railroad Company, at Fairfield, Alabama.

The power plant is in an isolated building in the rear of the main building. A tunnel seven feet wide and eight feet high extends from the



The sterilizing room of the hospital.

power house through the main building under the center of each wing and contains all service lines for heat, water, electric conduits, drains, and ventilating ducts. Branches are taken from the main lines in this tunnel through shafts to the various parts of the building.

In the power plant, which is divided into a boiler room and a pump room, there are two 175 horsepower water tube boilers; one 125 kilowatt, three phase, sixty cycle, 220 volt, turbo-generator; one 750 gallon motor driven fire pump; two house pumps; two boiler feed pumps; two vacuum pumps; two domestic water heaters; one eight ton refrigerating machine; two brine circulating pumps, as well as an ice making tank and a drinking water cooling tank. The transformers for stepping down the outside current are also located in the pump room. All of the equipment is motor driven, with the exception of the boiler feed pumps and vacuum pumps, which are steam driven.

In the boilers, by-product coke oven gas is used, which is piped from one of the company's plants some distance away. The plant is therefore entirely free from smoke and soot.

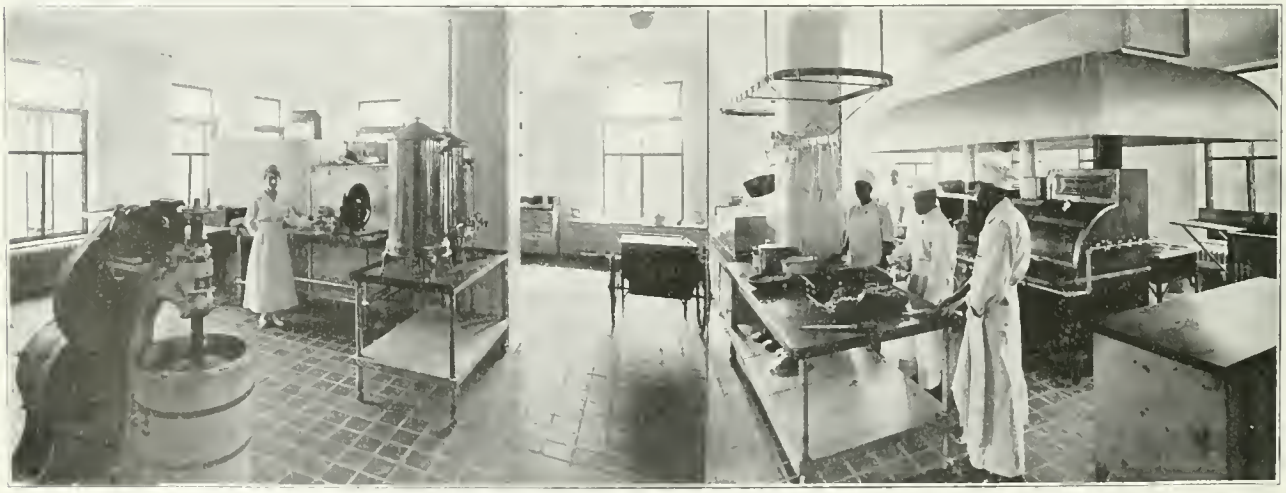
The stack is four feet six inches inside diameter and 115 feet high, so as to carry the gases well above the uppermost part of the main building. It has an octagonal base, faced with Bedford stone, and the shaft is of face brick, so that it matches the main building.

Steam is generated at one hundred pounds pressure and is supplied at this pressure to the laundry, being reduced to fifty pounds to supply steam to the sterilizers, disinfectors, blanket warmers, kitchen equipment, etc., throughout the building, and to virtually atmospheric pressure for supplying the heating system.

Heated by Vacuum System

The building is heated with a vacuum system, with overhead supply mains running through the attic and return mains carried in the pipe tunnel under the basement. The branch vacuum return lines are run through closed trenches under the basement floor. The radiators throughout the hospital are of the plain pattern, "hospital" type, with sections three inch centers instead of two and a half inch, so that they may be readily cleaned, and the radiation is of the legless type, being hung on the walls above the sanitary bases to facilitate sweeping and mopping underneath them.

All the rooms are equipped with automatically controlled temperature regulation, so that the temperature will not vary more than one degree above or below the temperature desired. This will not only add greatly to the comfort of the patients, but will also effect a saving of fuel. Many would think temperature control unnecessary in a place as far south as Birmingham, whereas the truth of the matter is that tempera-



The kitchen equipment is of the most modern type.

The fact that the roof is partly covered and partly open makes it adaptable for use in all weather.

ture regulation will effect a greater percentage of saving in a warm climate than in a cold climate. The average temperature for Birmingham from October to May is 50°. Therefore, if the temperature in the building is held at 70° instead of 75°, 25 per cent of the fuel will be saved.

Building Well Ventilated

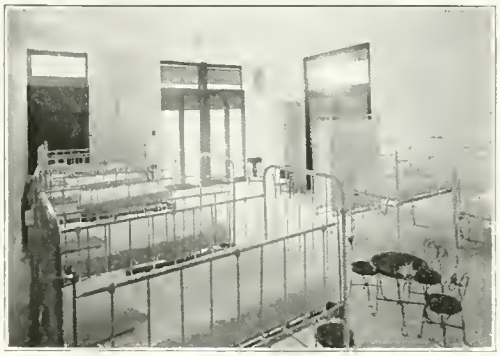
The entire hospital is well provided with mechanical ventilation, there being two systems to supply fresh, tempered, washed, and reheated air, with humidity control. The supply fans, air washers, and heating coils are located on the basement floor in the north and south wing annexes, with two general exhaust systems, with fans, located on the roof of the main building, and one kitchen exhaust fan located in the attic space in the east wing annex. From the two supply systems, air is furnished through the pipe tunnels under the basement floor, which are used as plenum ducts, and risers to the corridors in the different wings. The two general exhaust systems draw the air from the wards, diet kitchens, laboratories, cleanup closets, and toilet rooms, the air entering these rooms from the corridors through transoms over doors. The private rooms are not ventilated. In the wards and main rooms there are two openings into each ventilating duct exhausting air, one at the floor and one approximately eight feet above the floor; the upper opening being used in summer to draw the warm air from the top of the room and the lower opening being used in winter to draw the cool air from the lower part. The kitchen exhaust fan is provided with a by-pass and fire damper, so that in case any grease, which has collected in the duct, should ignite, the fire damper will fall, shutting off the fan and allowing the flames to pass direct to the roof.

Exceptionally high grade plumbing fixtures were used throughout and all concealed hot and cold water piping is of brass. As the hospital is at a considerable elevation, it was necessary to use a house tank on the roof, into which water is pumped from the two house pumps in the power plant.

The duplicate water heaters in the power plant are of the enclosed, steam coil type, each having a capacity to heat 1,500 gallons of water per hour. The hot water supply main is carried through the pipe tunnel, rising through the building with distributing main in the attic. The drop risers are extended from the attic main, supplying the various fixtures, and the bottoms of the risers are collected into a return main in the pipe tunnel, which is carried back to the heaters, giving a circulating system.

Power Plant Has Fire Pump

As there is not sufficient pressure in the mains at the building for fighting fire, a 750 gallon motor driven fire pump was installed in the power plant. This pump supplies three standpipes in the main building, supplying three hose cabinets on each floor. A loop fire main was also installed underground around the hospital building and



A section of the children's ward on the second floor.

power plant, with five double connection fire hydrants, which give ample fire protection.

The building has very complete laundry and kitchen equipment, as well as the very best of laboratory equipment.

While a 125 kilowatt turbo-generator has been installed in the power plant, this unit is for emergency service only; the main current being supplied from the Tennessee Coal, Iron and Railroad Company's transmission line at 6,600 volt, three phase, sixty cycle current. The Company has extended this transmission line from one of its own plants some distance away and the transmission line is carried underground on the hospital property. In the power plant two banks of three transformers each, totaling 60 K.V.A. for light, and 150 K.V.A. for power, are mounted on a platform in one corner of the pump room, stepping the voltage down to 220 volts for power and 220/110 volts for light. There is a switchboard in the pump room with incoming feeder panel, as well as generator panel and distributing feeder panels.

The building is well lighted. A complete nurses' silent call system has been installed, as well as an automatic interior telephone system. On the silent call system, there is a light at the door of each room and in addition a small light at each bed in the wards, and of course the lights at the annunciator at the nurses' station. The interior telephone system is of the full automatic selective talking type, with automatic central switchboard requiring no manual operation.

Elevators of Automatic Control

There are two passenger, and one combined passenger and service elevators in the building, with overhead machines of the worm gear type. The elevator platforms are all sufficiently large to carry cots and the elevators travel at a speed of 125 feet per minute. The elevators have automatic push button control and are also arranged for manual control. The cabs are of steel, and the cab gates as well as the doors are provided with automatic locking and contact devices so that the cars cannot start unless the gates are closed and the doors closed and locked.

The refrigerating plant in the pump room is of eight tons refrigerating capacity, and the compressor is motor driven. There is an ice making and brine storage tank, having the capacity to make 1,000 pounds of ice per day, and from which brine is circulated through the hospital by two circulating pumps. All of the refrigerators, including the small boxes in the diet kitchens, as well as the cold room in the morgue are brine cooled, so that no ice is carried through the building.

There is a drinking water cooling tank in the pump room, having the capacity to cool twenty-five gallons of water per hour, and the water is circulated through a supply and return main, with branch risers to the fountains and a circulating pump to insure positive circulation. There are three drinking fountains on each floor and other drinking water connections in some of the rooms.

The buildings are entirely fireproof. The floor construction is reinforced concrete using a unit system of metal domes with Shurebond lath bottoms for ceilings. The partitions are solid plastered, two inches thick, with self-supporting metal lath. The carrying walls are brick. The exterior is a buff mottled brick with buff terra cotta trimmings. The floors are terrazzo with sanitary terrazzo bases, except through the center of the wards rubber tile was laid flush with the terrazzo floor.

A large proportion of the employees being colored, it became necessary to provide for a double service, white and colored.

The laundry department of the hospital.

The basement has provisions for an outdoor clinic under the front wing. The side wings con-

A ward in section "C" on the first floor.

The operating room has light green tile walls and floors.

tain the quarters for the help, receiving room for patients, large sterilizing room, morgue, store rooms, with fan rooms and laundry in the rear.

The first floor has the administrative offices in the front wing. The side wings have wards and single rooms, one wing for white and one for colored patients. Clothes rooms for patients' clothes are provided for in each wing close to the ward. Diet kitchens are placed so as to reduce as much as possible the trip from the kitchen and elevators. The small wings attached to the rear of the side wings are for the purpose of isolating certain classes of patients. The wings are all arranged so that they can be shut off from the central corridor which contains the stairs and elevators, cutting off the main traffic through the hospital and thereby reducing noises to a minimum. The nurses' stations are located in the small octagonal rotunda outside the wards, from which both wards can be observed, as well as the entrances to the small isolation wings to the rear. The arrangement of these wings is similar on all floors. The kitchen and accessories and dining room for nurses and resident physicians are located in the rear wing of the first floor.

Children's Ward on Second Floor

The front wing on the second floor has the childrens' wards and the rear wing the pathological laboratories, x-ray rooms, record library, drug room and doctors' dressing room.

On the third floor front wing provisions are made for quarters for interns, and the rear wing has the operating rooms. The operating rooms have light green tile floors and walls. The green tile has proven to be very satisfactory, getting away from the glare of white tile which has generally been used.

The elevators and stairs extend to the roof, so that patients can be taken there. The roof is so arranged that the pavilion immediately in front of the elevators can be entirely closed with glass doors, the pavilion in front of this is roofed over, with open sides, while the side wings are entirely open with a four foot high balustrade around the sides, making it possible to take patients out on the roof in any kind of weather, or placing the patient according to his condition.

In addition to the roof garden, solariums are provided at the end of each ward. Five cottages connected by covered porches have been built in the rear of the main building for the accommodation of nurses. On the main driveway approaching the hospital are five cottages for the resident physicians.

The hospital has been in operation about a year and has proven to be very successful.

ILLINOIS DOWN-STATE HOSPITALS ORGANIZE

On May 19, at Springfield, Ill., a meeting of the down-state hospitals was held to organize an association of the smaller hospitals, and those from this section in accordance with an idea which has been discussed for some time previous. Officers were elected, and authorized to prepare a preamble or constitution and by-laws to be presented at the next meeting.

BELGIAN SURGEON SENT TO UNITED STATES

One of the recent guests of the Library and Service Bureau, was Dr. Louis Christophe, a Belgian surgeon, who has been sent to the United States by his government and the University of Liege. Dr. Christophe has spent several months at the Mayo Clinic, Rochester, and is now at the Crile Clinic in Cleveland. From there he is going to Boston, and he will return to his own country later, taking with him plans of American hospitals, and as complete information as he has been able to collect on the most modern systems of ventilation, heating, laundry service, cooking, elevators, etc.

Dr. R. B. Baldwin, president of the American Hospital Association, was recently authorized by its Board of Trustees to appoint a committee of five to study the formal relation between states and cities and the hospitals and dispensaries located therein, and to report its findings to the Association. The committee will probably submit a complete report at the West Baden convention.

PLANNING A HOSPITAL SYNTHETICALLY

By LOUIS J. FRANK, Superintendent, Beth Israel Hospital, New York City

In planning the new Beth Israel Hospital for New York City, the synthetic method was used. That is, the planning was done from small to big things, starting with details of equipment and placing, and working toward the exterior plan of the building. For fifteen years the staff of the hospital made notes and observations, classifying them under various headings. In other words they made as complete an index as possible of the contents of the hospital. Many authorities and experts from other institutions as well as their own experts were consulted before the plan was finally made. The interesting experiment was also tried of making actual models of the various departments.

THERE are men who build only with bricks and mortar, sand and lime, and the edifices they erect are as strong as their bricks and as cohesive as their mortar. Whatever grace they have is of external appearance. Like them of old who worshipped the gods in stone and clay and ultimately forgot their god in their identification of the image with the diety, so now the many who build, forget the function of the space which their tinseled ornaments decorate and marble walls enclose, and are content with the outer appearance, forgetting to scrutinize the inner purpose of the mansion. It is with spirit that man must build, if his work and his aim are to endure, for the strongest kiln-dried brick is but sand in the hands of time.

Man can build as man can reason. He may reason deductively, that is, analytically, or inductively, that is, synthetically. In the construction of hospitals builders have always followed the analytical plan. They have erected an edifice of certain cubical contents and have then apportioned this space into divisions suitable to minimum requirements, sacrificing very often convenience to the exigency of space. A certain percentage of the cubical contents had to be devoted to the kitchen, and another percentage to the operating room, and what could not be conceivably squeezed into the cubical contents was crowded into out-houses and roof structures and into nooks and crannies that have remained unaccounted for by this puzzle house that Jack built.

Hospital Planned Synthetically

In the planning of the new Beth Israel Hospital we followed an altogether different plan. We built up, synthesized, the structure from its component parts, and we placed each one of these parts in proper proximity to the others, so that all could function smoothly and harmoniously.

Some time ago it became apparent that we had to move from the old building. It was designed properly and correctly, according to the times, to orientation, and conveniences, but planned for a fewer number of beds, without scientific departments. For these and other reasons we desired to move. New York City is a world in itself; its surging population is constantly moving, so that a district inhabited by one race at one time may very shortly change its entire aspect and be entirely repopulated by another race. It is a flux of racial movement which is distinct and manifest. The Irish were followed by the Jews in the lower portion of Manhattan, and the Italians are now definitely following in the wake of the Jews, so that the Jewish population of New York is now located higher up in Manhattan, Bronx, Brooklyn, and Brownsville. We need a larger building, more accessible, free from encroachments, with room to expand.

We intend that the New Beth Israel serve not only as a hospital for the treatment of the acutely and chronically ill, but also as a health center where the hygienic and health questions of the well will be answered, and where by advice and teaching the healthy members of the community will be instructed in the prevention of diseases. In this regard, the site of the new building is especially suitable, since it is in the center of the district we wish to cover between the Battery and Fifty-ninth Street, East and North Rivers.

Site Chosen

To meet all these changing conditions, definite action was taken by the board of directors. Committees and subcommittees were appointed to find a proper location, having the advantages of light, air, close proximity to a park, freedom from noise, and suitable transit facilities. It was finally decided to locate on Livingston Place between Sixteenth and Seventeenth Streets, fronting Stuyvesant Park. All the advantages sought seemed to have been attained. The site is near the Second Avenue elevated station, the Third Avenue elevated station, the various subway lines, the Fourteenth Street crosstown, and the main New York thoroughfares, also the neighborhood is an institutional one, having the Post-Graduate Hos-

pital, Lying-In Hospital, Skin and Cancer Hospital, Eye and Ear Infirmary, Women's Hospital, De Milt Hospital, Hebrew Technical Institute for Girls, United Hebrew Charities, and other institutions. At first we purchased an interior irregular plot, ninety-five and one-half feet long by one hundred and twenty feet deep. We found that the building we had in mind would not fit in that space, so we bought the corner plot adjoining Seventeenth Street, measuring fifty-three feet by 120 feet. On this plot was a seven story apartment house, which we obtained with the intention of making alterations suitable for a nurses' training school, the basement and first floor to be used for hospital purposes. This gave us an area of 148½ feet by 120 feet, but a makeshift arrangement, so we finally bought the property on the corner of Sixteenth Street, measuring about thirty-five and one-half feet by 100 feet, and to this we added the adjoining building on Sixteenth Street, with a twenty foot frontage and fifty-three and one-half foot depth. This squared out the whole block, giving us an 184 foot frontage on the park, and 120 foot depth on Sixteenth and Seventeenth Streets.

It is due to the foresight and broad vision of the chairman of the building committee, Mr. I. L. Phillips, that the site on Livingston Place was chosen. Also, due to the business sagacity, level headed judgment, tact, and industry of Mr. Phillips, we were able to purchase the ground and property for a fraction of the price asked for it and thus save the community a very large sum of money.

Architect a Consultant

In the construction of the hospital, it seems to me that the architect should serve in the capacity of a consultant. By this I mean that the architect should be instructed exactly as to what we desire, rather than that we should be compelled to mould ourselves into quarters which he may think suitable for us. An architect is a theorist. He can see to it that the structural lines are consonant; that there be no medley of Doric, Ionic, and Corinthian columns, that the sense of artistic proportion be satisfied, that grace and beauty and service be planned to make a harmonious whole. But he is unacquainted with the practical work of the hospital kitchen, the x-ray department, the operating room, the wards, etc. He cannot conceive of the importance of little things which make for efficiency, of the interrelation of the various departments, of the proper division of each department into its compartments, etc., and we thought that it might, perhaps, be more fruitful to synthesize the hospital rather than analyze it, to plan each chamber of each department instead of each chamber as a whole, and then to interlock them so that they should be most suitably located in relation to each other.

In order to help us in making the plans for the new hospital, Mr. L. A. Abramson, the architect, assigned to us one of his expert assistants who helped us in drawing up the floor plans, instructed us where windows should be located, and on many practical points which only an architect can know, besides visiting with me many institutions and hotels and holding conferences with various heads of departments and workers in their special fields.

Practical Knowledge Taken Into Account

If one wants to get practical knowledge, one has to go to those who are practical. The kitchen chef knows more about the actual cuisine requirements than the president of the board of directors, or the superintendent, or the chairman of the building committee, or the architect. We therefore, decided to call into consultation the heads of the various hospital departments and inquire of them what plans they had for their departments in an ideal hospital. We also visited hospitals and other institutions, to study carefully various problems in detail. It is in the "little things" that one meets snags. To study nature one has to use the microscope much more than the telescope. It is our plan that all shall contribute their best to the construction of the hospital, for the proper conduct of an institution largely depends upon the obscure tasks which only the doer really understands. There are wheels within wheels, and cogs within cogs in hospital management. Let one cog miss and the whole machinery is deranged.

Originally we followed no prearranged scheme in planning the hospital. For fifteen years we made notes and observations, classifying these remarks under various headings. In other words, we made as complete an index as we could of the contents of the hospital, before detailing it. Thus, for example, we itemized the various necessities of the operating room and accessories before we assigned place and space to each of these essentials. It is a curious method, writing the index of the book before the table of contents, but we believe that in this way nothing will be overlooked, and the whole will be more systematically and harmoniously arranged.

We consulted many authorities and interviewed our own experts and experts in other institutions before the final plan was made. We did not follow any individual's hobby. Our great aim was so to construct that a new administrator, unac-

quainted with the plan and scope of the work could easily fall into the scheme of things and proceed without much study and consideration. For it is not the wise architect who so plans and builds that, should the present executive become incapacitated, the work of the institution must be entirely rearranged to suit the ideas and understanding of the new management. Things should be so preconceived that the machinery should run smoothly, without grinding of the brakes and with no stalling of the motor, when a new man of ordinary intelligence takes the driver's seat.

We have not been satisfied with grapho-cellulose architecture. Cold drawings on paper fail to show actual realities, and artists are known to draw so that faults and inconveniences are overlooked. Therefore, we decided to make actual models of the actual size of the various departments of the hospital. We equipped those rooms with all their paraphernalia and we experimented with the actual patient; that is, we built several individual rooms, the utility rooms, the operating room, the diet kitchen, etc., and we invited experts to come and examine and criticize, and we then incorporated the beneficial suggestions.

To the various items we assigned a certain area, and we so located them on the map of the hospital that three main considerations were accounted for. First, that the convenience and comfort of the patient, the things of paramount importance, were satisfied; second, that the problems of the physician, the nurse, and the attendant were solved; and third, that the visitor was duly impressed with the attention given to the patient, and with the exertion of the authorities, properly to receive and welcome the public.

Patient, Staff, and Public Considered

The facilities were always studied to see that the patient was well served, whether he could be carried about without loss of time, and without exposure or fatigue. Due attention was given to the convenience of the workers, whose time and effort must be conserved, and for whom all labor saving devices and arrangements should be installed. The visitor was also considered in the plans. He should be able to go about the building without a guide and without feeling lost in the helpless maze. He will observe the quiet and will sense the sympathetic atmosphere. Every department will have a show place for the visitor, the laboratory, its museum; the x-ray department, its demonstration room; the children's ward, its open and indoor playgrounds; the adult wards, their day rooms; the operating room, its amphitheatre, etc.

We have repeatedly affirmed that most hospitals were not built for the absolute comfort of the patient, and that in many hospitals the comfort and convenience of the attending were the only important considerations. Most people dislike to go to a hospital because they dread being huddled into beds where they lose their identity and become a number, resembling in this regard the convict who in the record is spoken of as number so and so. As soon as he can afford it, the average patient seeks privacy. He wants quiet and drawn shades. He wants peace, so that his nerves may be rested. The ordinary individual has a sense of modesty, a desire not to impose upon his neighbor if he can help it.

Decided on Private Rooms

It had, therefore, occurred to us long ago that each patient, rich or poor, should be assigned to an individual room during his period of illness. What are the advantages of the individual room system for every patient? They are so many that I will discuss them in another paper; I know of no disadvantages. It is certain that no one would recommend that a wealthy patient be assigned a bed in a public ward, for the advantages that he may derive from the ward attention. The time, it seems to me, has come, when all patients are to be given the same opportunity to grasp health. Briefly, the advantages of the private individual room may be summed up under the heading "Comfort of the sick individual"—his psychic comfort, his nerve rest, the gratification of his whims, his hygienic and therapeutic measures altogether satisfied with dispatch.

There are certain problems that confront us in the construction and management of the Beth Israel Hospital, that are specific for us, and in the solution of which we have had more experience than any other hospital executives. These are the questions of the observance of the Jewish ritual.

We are an orthodox Hebrew institution. I wish to stress the word "orthodox." In the matter of religion, toleration of opinion and of observation is an evidence of a cultured, broadminded individual. In the great, liberty loving nations, there are groups of citizens who have varying theological opinions, who live side by side in harmony and peace, because they consider these questions as personal and private. So also among the Jews there are those who worship their God according to the specific rules laid down by Moses, and others who follow their own dictates of conscience. It is useless to attempt to unify religious opinions. While the orthodox Jew tolerates the belief of his neighbors and only asks to be allowed to follow his own method of worship, his neighbors are

ever attempting to do missionary work, to apostatize him to some reform or to another religion.

He who is ignorant of his way can be easily led through devious and wandering paths. Knowledge is often wanting in the man who wishes to form anew the religious creeds of the orthodox Jew. Usually he has learned his letters in Hebrew, has sat at the feet of rabbis, and can quote the Bible or Talmud to illustrate a point. In this regard Jewish education seems to be a leveler of classes, for I have known carpenters and masons able to quote the ancient tomes with great facility and often with clever felicity. For these Jews, our hospital is a haven in time of sickness. All other hospitals seem to discriminate against them. Even the other Jewish hospitals make no provision for their care in times of illness, for they mock them by serving them meat and milk simultaneously, or by inviting them to eat of the forbidden flesh. A religious Jew, like one that lacks religion, will refuse to wear a cross. There is a certain pride attached to this subject, even if one is unorthodox. The orthodox Jew would certainly rather starve than eat meat and milk, or the flesh of the swine, or meat not prepared in accordance with the Hebrew dietary laws.

Our function is to minister to these Jews. In this particular way we spare no expense or trouble. It has been my pleasure to have interviews with our learned rabbis to obtain their advice on moot questions. In the new hospital we have made the ritual observation fool proof. We have planned for separate kitchens, for closets to house the utensils for the varying meals, for a supervision of koshers, and a staff of assistants to see that the ritual is enforced. We have listed all foods, and have interdicted certain ones that are not kosher. In the new hospital we shall have a synagogue in the main auditorium and we have taken care that the holy scrolls be kept in a chamber altogether isolated. There will be a "succoth" for the feast of the tabernacles and arrangements for the observance of the Seder during Passover, and for the lighting of candles during "Chanuka." We have been extremely careful in minute details.

In the question of autopsies, while the board is convinced of their urgent need and has adopted a resolution sanctioning them, we have corresponded with many rabbis, being in communication even with Jerusalem, to obtain their opinion and advice.

All the credit for the progressive spirit of the Beth Israel Hospital belongs to Mr. Joseph H. Cohen, the president of the board of directors. In Mr. Cohen we have the blending of the philosopher and enthusiast, the man who follows cross cuts and straight paths to obtain his aim, yet never tramples on the privileges or opinions of others. It is due to his wide vision, his encouragement, his clear reasoning, that we have forged ahead to "newer fields and greener pastures," and his is the praise for what we have accomplished and hope to accomplish.

It has been our endeavor to visualize the future and build for it. The greatest of Jewish physicians, Rambam, wrote long ago, "The eyes look forward not backward," yet it seems that this observation has been forgotten by the Jewish race. They always look sun-ward, but the years of persecution have made them timid, and they are perpetually casting their looks backward as if afraid of their own shadows. We who are convinced of the justice of our cause and of the dignity and nobility of our purpose must not heed our detractors or those who wish to lead us astray; for us the encouragement of the Bible is always present and we will follow it. "Fear not and have courage, for the Lord is with thee."

LIBRARY AND SERVICE BUREAU TO HAVE EXHIBIT

Realizing the important service which is being rendered by the Hospital Library and Service Bureau, whose headquarters are at 22 East Ontario Street, Chicago, the American Hospital Association has invited the Library to have an exhibit at the annual convention to be held at West Baden. The Association has very generously contributed sufficient space to permit of a very comprehensive exhibit.

Since the subject of hospital construction is the one upon which the Library has received the greatest number of inquiries, a large portion of the exhibit will be made up of floor plans of hospitals, sanatoriums, health centers, dispensaries, nurses' homes, and allied institutions. It is expected that plans of some three hundred or more institutions will be available for exhibit purposes. In connection with the plans, it is expected that the list of architects specializing in hospital construction will be freely used. This list, giving, as it does, the institutions designed by the various architects, enables the user to form a fairly accurate opinion of the type of work being done by the individual architects.

Complete subject, author, title, and analytical indexes are being prepared of the various hospital journals. Such parts of these indexes as are complete will be included in the exhibit, together with copies of the journals indexed. Complete sets of record forms used in hospitals of various types and sizes will also be shown, together with various books on the classification of diseases. It is hoped that by the time the convention meets similar records from dispensaries may have been assembled. A limited number of books, journals, reprints, and pamphlets on the various phases of hospital construction, equipment, and administration will also be shown.

The material being assembled by the Hospital Library and Service Bureau is so varied in type and so extensive that only a very small portion of it could be included in the exhibit. The object in having such an exhibit is rather to bring the hospitals in contact with the service being rendered and to acquaint them more fully with the purpose and scope of the Hospital Library and Service Bureau and the manner in which it functions.

THE INTERIOR ARRANGEMENT OF HOSPITALS

By PERRY W. SWERN, of Berlin, Swern and Randall, Architects and Engineers, Chicago, Ill.

THERE is nothing more vital to the hospital than a correct interior arrangement. Most hospital buildings have "just happened"; in many cases a clear conception and analysis of how the buildings were to be used has surely been lacking.

Many hospital executives are struggling with problems of administration, nursing, and service which are caused by improper physical arrangement of their buildings. Human energy as well as supplies is being wasted daily. Now the thing is to find the correction of this evil which is so greatly affecting the efficiency of our hospitals and holding them back in their rightful progress.

In the first place, hospital directors or workers know the kind of business that is being carried on in their buildings. They have a goal in view, as to the kind of service they desire to give their communities. Has this ever been analyzed and written down? Can they turn to their records and show in a few brief sentences what their hospitals are endeavoring to do? Is it publicly known and has it the approval of the community? Is it flexible enough to meet changing requirements as the community develops?

The answers to these questions establish to a large extent the policy of the hospital. This policy, together with the physical surroundings, establishes the arrangement of the building and is very important, in fact, it is fundamental.

First of all, a policy that will serve the community and survive the "law of supply and demand" must be established. This is the duty of the board of directors, and is the first step toward obtaining a correct interior arrangement. An architect cannot prepare a truly successful plan unless he knows just what business the building is to house.

Hospital plans cannot be standardized, not even parts of them, there is too much variation in the nature of the organizations conducting hospitals, and the kind of work they desire to accomplish, to permit standardization.

Each and every case must be diagnosed separately and all of the symptoms analyzed by an impartial judge, preferably an outsider who does not know of the politics or rivalry of the community. These seem big at times, but they are really only passing shadows, and should not influence the real policy of the hospital.

After the policy has been established it then becomes the duty of the architect to provide a workshop in which the superintendent can put his machine to work, and turn out his product at the lowest possible cost, and with the least consumption of energy. This is rather a cold way to express the functioning of a hospital, and must not be construed to mean sacrificing the personal element of the workers or neglecting the psychology of the patient, for both these are necessary to carry out the policy.

The analysis of hospital policies shows a few fundamental, basic requirements common in all of them, varying only in their relative importance to each other. These must be met squarely and answered satisfactorily from every angle if the interior arrangement is to be successful. It might be well to state some of these requirements:

First: Every hospital is organized to render the best care for the sick, to give all the comforts possible, and to hasten recovery.

Second: Every hospital is operated with the idea of increasing the medical and nursing facilities of the community and in most cases to provide means for educational and research work.

Third: The hospital is to be popular and so operated that the majority of the community can partake of its services.

Fourth: The erection and operation of buildings on a self-supporting basis which will make it possible to give these and many other individual services.

Each particular case will have other important individual requirements which may even take precedence over some of the requirements just mentioned.

There are several ways to proceed with the development of the interior arrangement of a hospital, but first of all we should realize some of the working facts that affect the hospital operation, and we must have them so thoroughly in mind and visualized that the layouts will comply with their dictation.

The time and energy of the nursing personnel must be conserved and every inch of waste motion eliminated.

The time and energy of the medical staff, interns, or visiting doctors, are valuable and must not be wasted.

The means of distribution of provisions and supplies is very important, and must be handled efficiently, and must promote conservation.

The securing of a flexible arrangement of the various facilities and a maximum occupation of beds is essential.

The use of simple construction and the arrangement of the utilities must be such that maintenance will be at a minimum.

*Read at the annual meeting of the Wisconsin Hospital Association, May 25, 1921.

A plan which seriously violates any one of these facts should not be considered.

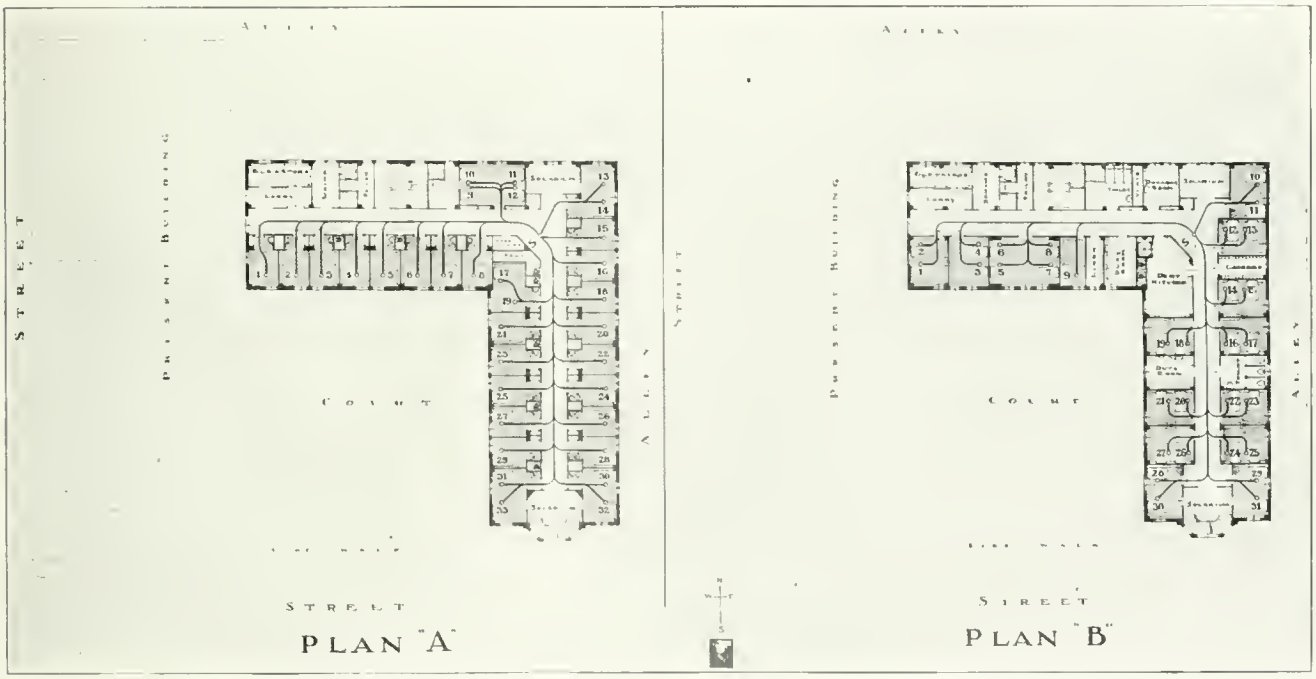
These facts, namely, conserving nursing energy, conserving the energy of the doctors, conserving supplies, increasing bed occupancy, and simplicity of construction, are so vital that I would like to enlarge a little on each one to bring home the importance of a thorough knowledge of the effect of these facts on the physical arrangement of buildings.

Anyone who has nursed in a hospital or watched a nurse's procedure in her daily work realizes that she spends a lot of time doing things that really are not nursing. This has been excused as being essential to her education, and thus the nurse is allowed to go on doing drudgery and spending a goodly portion of her time in wasted energy. You will probably be surprised to hear that in some hospitals the nurses travel more than twelve miles in an eight hour shift—in other words, three hours tramping corridors and five hours nursing. No wonder it becomes necessary at times to hold out extra inducements to get intelligent girls to enter training.

The way this human energy has been wasted in some hospitals is almost criminal and would have been eliminated years ago if hospitals were under the pressure of keen competition that other business enterprises are under.

Enough of sermonizing—now to the facts. A study of the nurse's calls shows that about 75 per cent of them are comparatively simple and could be disposed of without the nurse's leaving the room if she had certain equipment at her disposal. The absurdity is very apparent of a nurse being required to walk perhaps a hundred feet to hear the request of a patient for a bed pan, which makes it necessary for her to retrace her steps to the duty room, then travel back to the patient and finally return the equipment to the duty room. Hospital directors realize this and have made attempts to rectify it by putting the patients in private rooms and providing private baths or communicating baths similar to modern hotel planning. This produces a cumbersome plan and materially increases the length of the nursing radius.

A patient, while similar to a hotel guest in many ways, is also quite different. For instance,



Typical Floor Plans, German Evangelical Deaconess Hospital, Chicago

NURSING RADIUS	
Summation of distances from "S" to beds (1-31)	1,823 ft.
1823 ÷ 31, giving nursing radius of	58.8 ft.
Summation of distances to the left of "S"	780 ft.
780 ÷ No. 4, giving nursing radius to left	55.7 ft.
Summation of distances from "S" to beds (1-31)	1,240.5 ft.
1240.5 ÷ 19, giving nursing radius to right	65.3 ft.
AREAS	
Total floor area	7,510 sq. ft.
Total area in patients' rooms	3,149 sq. ft.
Area per patient (3149 ÷ 33)	95.6 sq. ft.
Height of ceiling required (1000 ÷ 95.6)	10.5 sq. ft.
CUBIC CONTENTS	
Total contents per floor (7510 × 10.5)	78,900 cu. ft.
Cubic contents per bed (78,900 ÷ 33)	2,390 cu. ft.
COSTS	
Cost per floor, 78,900 cu. ft. × 64c	$50,500.00
Cost per bed, $50,500 ÷ 33	1,530.00

NURSING RADIUS	
Summation of distances from "S" to all beds	2,133 ft.
Nursing radius (2133 ÷ 31)	68.8 ft.
Summation of distances to the left of "S"	803 ft.
Left nursing radius (803 ÷ 11)	73 ft.
Summation of distances to the right of "S"	1,330 ft.
Right nursing radius (1330 ÷ 20)	66.5 ft.
AREAS	
Total floor area	7,510 sq. ft.
Total area in patients' rooms	2,752 sq. ft.
Area per patient (2752 ÷ 31)	88.8 sq. ft.
Height of ceiling required (1000 ÷ 88.8)	11.25 sq. ft.
CUBIC CONTENTS	
Total contents per floor (7510 × 11.25)	84,400 cu. ft.
Cubic contents per bed (84,400 ÷ 31)	2,722 cu. ft.
COSTS	
Cost per floor, 84,400 cu. ft. × 64c	$54,000.00
Cost per bed, 54,000 ÷ 31	1,740.00

how many tub baths are given to patients while in the hospital? Tubs are really unimportant. "Room with bath" has been the hotel slogan and has revolutionized the hotel business. "Room with individual utilities" should be the hospital slogan. It will make the "hotel for the sick" more popular and keep its business on a more even keel.

I am sure that hospital superintendents will agree with me that if 75 per cent of a hospital's patients could be cared for in private rooms, and the rest in small wards, the situation would be ideal. I am speaking of general hospitals serving an average community, not the special hospital or sanatorium. How to produce this arrangement is the problem.

First: The nursing radius must be small, smaller than it is in most hospitals. To make this possible, the patients must be kept close to the nursing station. The interposing of rooms for uses other than patients' rooms, such as duty rooms or diet kitchens, between the station and other patients is very serious and should not be done without consideration of the consequences.

Second: The width of the patients' rooms should be very zealously guarded and not an inch put in that is not needed. Keep the normal distance between patients as small as possible.

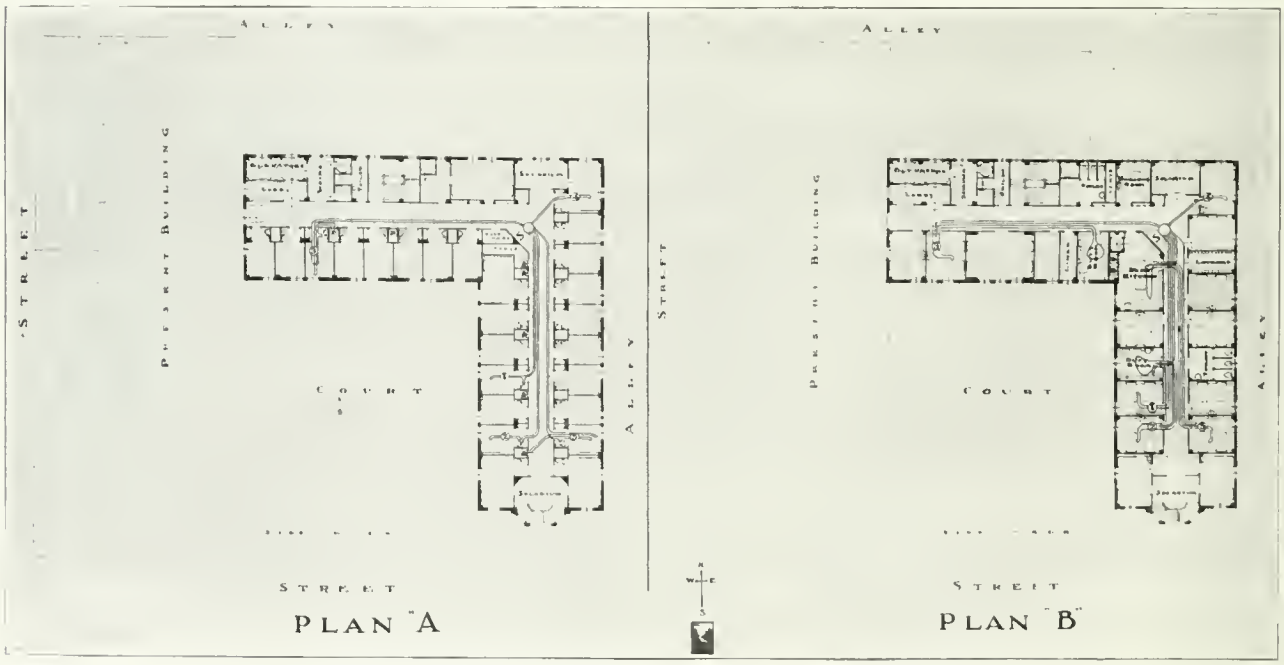
Third: Arrange the doors and windows and equipment so that every f ot of the room serves a purpose. Remember that a successful plan will always express itself pleasingly on the exterior of the building. Do not let the architect increase the nursing radius purely to gain an exterior architectural effect. It is not necessary.

The nursing radius means the summation of all the distances from each patient's bed to the nursing station, divided by the number of beds per floor; in other words, an average distance; an index to plan efficiency.

The conservation of the energy and the time of the medical staff means more time for the doctors with their patients, better examinations, histories, and consultations. The small private room with "individual utilities" accomplishes this by decreasing the tramping of long corridors, the necessity of arranging bed screens and retiring to other rooms for consultations.

The conservation of provisions and supplies is so important and is such a big subject, that time will only permit me to touch lightly on it. Briefly, the diet kitchens located on the different nursing floors must be eliminated. This space belongs to the nursing departments and should be used as such. Cooking food in a number of places is wasteful. This must be done collectively where proper supervision can be given.

Eliminate the many linen and supply rooms



Typical Floor Plans, German Evangelical Deaconess Hospital, Chicago.

FIVE MOST FREQUENT CALLS

(1)	Drink of water—Travel from station to room, to utilities, to patient, to utilities, and return to station	128 ft.
(2)	Request for bed-pan or urinal bottle—Same travel as for (1)	170 ft.
(3)	Hot or cold applications—Travel from station to room, to telephone, to dumbwaiter, to utilities, to patient, and return to station	215 ft.
(4)	Adjustment of position—Travel from station to patient and return to station	47 ft.
(5)	Intermediate or special diets Travel from station to room, to telephone, to dumbwaiter, to patient, and return to station	222 ft.
	Total travel for five calls	782 ft.

FIVE MOST FREQUENT CALLS

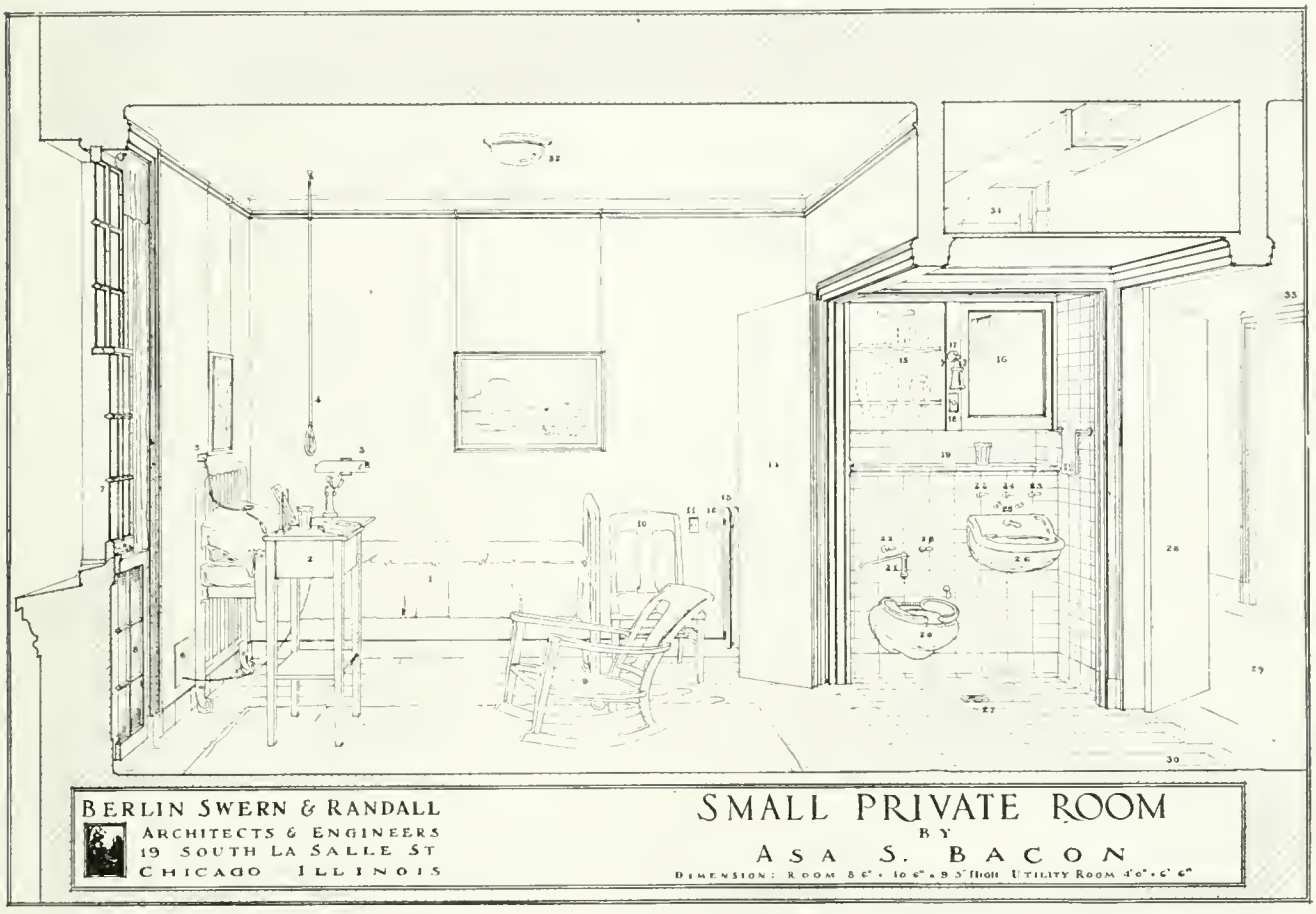
(1)	Drink of water—Travel from station to ward to lavatory, to patient, and return to station	140 ft.
(2)	Request for bed-pan or urinal bottle—Travel from station to ward, to duty room, back to patient, back to duty room and return to station	252 ft.
(3)	Hot or cold applications—Travel from station to ward, to duty room, back to patient and return to station	314 ft.
(4)	Adjustment of position—Travel from station to patient and return to station	47 ft.
(5)	Intermediate or special diets—Travel from station to ward, to diet kitchen, back to patient, back to kitchen and return to station	342 ft.
	Total travel for five calls	1,095 ft.

throughout the house and turn this space into nursing facilities. A positive check of supplies will bring about an enormous shrinkage in the volume used. Rules and regulations are hard to enforce.

The methods of communication and transportation between the nursing floors and service departments requires a thorough knowledge of proven mechanical equipment in order to judge which is best for the particular hospital problem under consideration. It is impossible to state facts or advise the use of any particular system on account of the extreme variation in plans. Generally, high speed dumb waiters operating from the service floor to the nursing floors, either located together or strategically placed around a central kitchen, will suffice. In other cases the use of service elevators with vacuum carts will be the best.

We must keep in mind the fact that vertical transportation is cheaper and quicker than horizontal transportation. It is mechanical means compared with carrying supplies or pushing carts with human energy, and for this reason, any plan that makes it necessary to transport food or supplies horizontally any great distance is open to criticism.

The central kitchen, with the serving stations adjoining, is preferable to the scattering of diet kitchens throughout the building, for many reasons, besides the actual economy of provisions. It means that every tray can be inspected by the dietitian before it goes to the patient. Special diets can be controlled and records made of food consumed or refused. The garbage and dish washing are cared for collectively, and all this, together with the elimination of floor cooking,



1. Hospital bed.
2. Nursing table with sliding top for use as a bedside table.
3. Adjustable and removable bedside light, with pull chain control.
4. Adjustable and removable strap for patient to assist in changing position in bed.
5. Removable signal cord and button.
6. Telephone box, recessed in wall.
7. Double hung window.
8. Screen secretly attached to lower sash, so arranged that patients cannot jump out of windows.
9. Easy chair.
10. Straight-back chair.
11. Electric plug for inspection and examination extension cords.
12. Vacuum cleaning outlet.
13. Radiator.
14. Three-leave door to enclose utilities, also forms isolation room and acts as a bed screen.
15. Case to house utilities (bed pan, urinal bottle, specimen bottles, sputum dish, and any other equipment need for the case in hand.)
16. Case for toilet and personal articles of the patient.
17. Electric light.
18. Electric plug outlet for special equipment.
19. Recess shelf for articles in use.
20. Typical wall-hung water closet, with open front and back seat.
21. Swivel spout for cleansing bedpans and other equipment.
22. Cold water faucets.
23. Hot water faucets.
24. Drinking water faucets.
25. Hooks for wringing hot stupes.
26. Typical Wall-hung lavatory.
27. Floor drain.
28. Door to corridor (double acting).
29. Corridor.
30. Closet on opposite side of utility room for patients' clothes, etc.
31. Exhaust ventilation from utility rooms.
32. General illumination of room controlled by elbow-operated switch at door.
33. Individual room signal light.

removes the many objectionable and distracting odors, and feeding places for vermin. In almost every hospital the setting up of trays in the diet kitchen is considered a chore by the nursing personnel. They do a great deal more of it than is required to perfect this part of their training. The central kitchen solves this problem and releases the floor nurse for more concentrated nursing.

There are almost as many reasons for combining the storerooms and thus securing a positive record of supplies used, by rooms, making it possible to charge extra if necessary, for unusual consumption, thus cutting down the general overhead loss and broken equipment charge.

The private room will increase the bed occupancy and will make it possible for a 100-bed hospital of the room type to do the work of a 125-bed hospital of the ward type. Patients are turned away daily from hospitals where there are vacant beds. For instance, a surgical case cannot take advantage of a vacancy in the medical ward, an arrangement of facilities which produces such a condition is very inefficient. A patient, no matter what his case may be, does not jeopardize any other patients if he is cared for in a private room with individual utilities.

I hear on every side the statement that private rooms are ideal, but that the cost of building such facilities is prohibitive, and that it will cost more per capita for the care of patients so housed. This is a mistaken idea; the accompanying diagram illustrates a specific problem laid out both ways, private rooms versus wards. The facts will open your eyes. It is usually possible with a given floor area to place more patients in small rooms with individual utilities than to place them in either large or small wards. Further, the actual cubic contents of the small room building will be less than the ward type. Both of these facts will allow considerable increase in the cost per cubic foot for the same bed capacity and still not exceed the funds required for a ward type hospital. The size of the hospital affects this ratio somewhat, buildings of twenty to seventy-five beds will cost slightly more in private rooms; with buildings of seventy-five to two hundred beds it is an even chance, depending upon the features of the property; over two hundred beds the small room plan invariably wins out.

The cost of operation per capita is dependent upon the cost of nursing and food service principally; adopt the plan that has the shortest nursing radius and requires the fewest steps to answer the calls. It will take fewer nurses in training, and a smaller number of specials and supervisors. The individual utilities will reduce the average call travel 25 per cent. The patient likes to know where his drink of water comes from and that the equipment he is using is not being passed around to others promiscuously. Furthermore, many calls can be eliminated by the patient doing things for himself if facilities are available and convenient. The feeling of security and individual attention helps the patient's mental attitude.

Briefly, hospitals must throw off the yoke of principles discarded years ago in other business enterprises, and change the institutional hospital into a hotel for the sick. They must consider and treat their patients as guests; there will be more of them. The interior arrangement of the building must be right to do this, so it must not be slighted or treated lightly. It is the backbone of the hospital's success.

I would like to impress upon the minds of superintendents some "don'ts":

Don't travel around visiting other hospitals collecting a lot of ideas and expect to secure an efficient arrangement by patching the various ideas together, unless you can spend sufficient time at each building to clearly understand their policy and problems, and compare them with yours.

Don't ask several architects to submit sketches in competition. Architecture is a profession and, as in medicine, a correct diagnosis of your problem cannot be given until all the symptoms are known and their relative importance established. The sketches must be the result of much study and many consultations, to mean anything.

Don't divide the responsibility of planning your hospital between a hospital consultant and an architect. It is dangerous. The architect will blame the consultant and the consultant the architect, when afterwards your hospital does not prove efficient.

Don't take for granted that some other community has just the same problems as yours and that their hospital will fit your needs. So far I have not been able to discover two parallel cases.

Don't start with the consideration of details, they are important, of course, but will easily fall in line if the basic physical arrangement is correct.

A successful interior arrangement is dependent upon a thorough knowledge of the problem in hand; a hospital plan cannot be guessed at. It must be conceived by someone capable of seeing the building, not only built, but in actual operation, before a shovel of dirt is turned. Otherwise the new building will fall in the class of an ordinary hospital, and the dream of a lifetime will be only partially realized.

To summarize, let me say that, first, we must establish our hospital policy; then analyze this policy and outline the fundamental basic requirements according to their relative importance; then secure the services of architects who know how to conserve nursing, medical service, provisions and supplies, and apply the facts of flexible bed capacity and simplicity of construction to your problem.

In our moments of tete-a-tete with the infinite, how different life looks. How all that usually occupies and excites us becomes suddenly puerile, frivolous, vain.

THE CARE OF RECORDS OF THE MASSACHUSETTS GENERAL HOSPITAL

By GRACE WHITING MYERS, Librarian, Massachusetts General Hospital, Boston, Mass.

WHEN a patient is admitted to the hospital, a slip is filled out which includes these items: registration number; date of admission; ward; service (medical or surgical); name in full, including middle name (initials are never used); residence—also in full—street, number, city or town, and state; sex; age; color; married, single, or widowed; industry and occupation; whether or not a re-entry; birthplace, and birthplaces of father and mother; name and full address of a relative or friend; name and full address of another friend, whose occupation may make such address a permanent one; and name and full address of patient's family physician, if such there be.

There are other data upon this admission slip, but as they are not concerned with the records, they have no particular value in this description. This slip is filled out by the admitting clerk, who at this time affixes the registration number. The slip is in duplicate, by means of a carbon placed between, one slip going to the ward with the patient, and the other being sent to the record room. The data at the head of the charts (referred to later) are typewritten by a record clerk. For this purpose the original slips go to the record room twice a day, at 9 a. m. and 3 p. m., thus covering all admissions. As soon as charts are printed, they are sent to the various wards where they belong. The admission slips are returned to the admitting office for use as follows.

In this office is a book known as the "entrance-book," a large volume, capable of receiving upon one line, which runs straight across two pages from edge to edge as the book lies open, the data contained on the admission slip above referred to. In addition, there is a column at the left-hand edge of the left-hand page for "hospital number," and another near the right-hand edge of the right-hand page for the date of discharge, to be inserted at the proper time. The "hospital number" is the number by which a patient is referred to as long as he remains in the hospital. Each line of the entrance-book is numbered and a patient is given the number of the line upon which his entrance is recorded. One series of numbers only is used, these numbers running through all the various "services" of the hospital, thus avoiding any chance of a number being wrongly applied (through carelessness in recording), as is possible where one set of numbers is given to a medical service, and a duplicate set to a surgical service.

When the clerk in charge of the entrance-book is ready to record the entrances for a day, she takes each admission slip in turn, as it is numbered, and copies the various data from the slip into the book, upon the line bearing the corresponding number. These slips are then returned to the record room, where the name cards (Fig. 1) are printed, recording all data possible at this time. These cards are temporarily filed in a desk box, to be completed when patient is discharged. The admission slips are sorted out according to service, filed alphabetically according to name, and reserved for future use. The slip which is sent to the ward with the patient is known as the "nurse's slip." In emergency cases, admitted hurriedly through the emergency ward, it may not have been possible to obtain accurate information at the time of entrance. A clerk from the admitting office looks up all such cases at a time when the patient, or some friend, can verify or supply needed data. These corrections are later made upon the charts, after the record has been finally handed in.

Writing the Record

The completed history of a patient is the joint work of house officer and nurse. The charts of temperature, pulse, and respiration are kept by the nurse, and she also checks off all orders for medication. In the case of the patient's being a re-entry, his former record, or records, must be looked up by a house officer, and reference made to such in the body of the record. If the patient has been transferred from another service, or is transferred to another service, reference to such transfer is made on the line indicated. Diagnosis and complications (if there be any), are written by the senior house officer, and in case of death and autopsy the number of the autopsy is recorded as "Path. No." (See next page, Directions for Work on Records.)

The body of the record is written by the house officer and must carefully cover, in the beginning, these points: family history, past history, social history, present illness, and physical examination. Then follow the daily notes, which must be written in all cases as often as twice a week, and more often if anything of importance occurs. In surgical cases coming to operation, a full descrip-

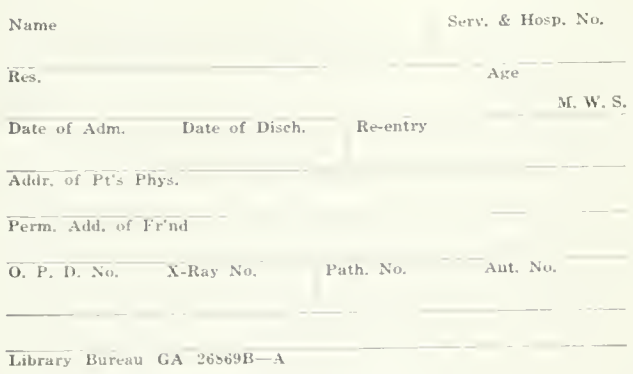


FIG. 1. Name Card.

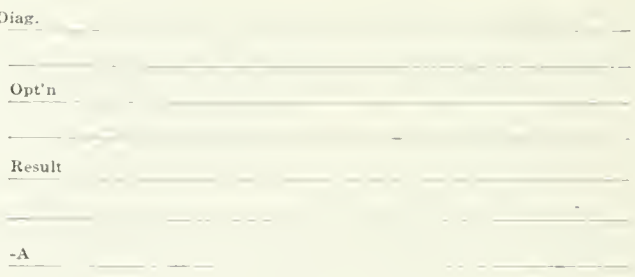


Fig. 2. Reverse of Name Card.

tion of the operation is required. This is recorded on a special "Surgical Sheet," which also provides for a full record of anesthesia, and notes by the operating surgeon. Reports upon all x-ray examinations must be fully made, being copied verbatim according to a slip sent from the x-ray department. Daily notes continue to the time the patient is discharged, when a statement is made as to where he went, whether to the convalescent hospital, the out-patient department, to his own doctor, or to some other hospital. If a patient is discharged against advice, untreated, or if he dies, statement to this effect is made; no other condition is noted. Throughout all records special use is made of red ink, analyses of all sorts, blood, urine, sputum, and feces being recorded in the color; and in the daily notes on surgical cases, under the proper date, is recorded the place where the operation was done (which operating room), the name of the surgeon, the anesthetic administered, and the technical name of the operation: e. g., gastro-enterostomy, or cholecystostomy, etc. In Fig. 1 will be noticed a line marked "Address of Patient's Physician." This is intended for the name of the family physician; and if there is none, no name should be recorded here. It is for use in the follow-up work, hereinafter described.

In addition to the chart sheet and those for writing histories, there is one for the record of all medicines and treatments ordered and given, and one for laboratory notes of all sorts. On the back of the latter, x-ray reports are copied, and questions asked of consultants are written, with their answers immediately below. Special sheets are used for diabetic cases; there is an extra sheet for urine analysis, to be used in cases of long duration, where frequent examinations are necessary; and for infants a special form for recording feedings. The surgical sheet has already been mentioned. All these sheets must be carefully kept together in the ward, and after the patient is discharged and the history completed, sent with the history to the record room at the proper time. Pathological reports, and anatomical diagnoses are typewritten on special forms and sent from the laboratory as promptly as possible to the record room to be filed with respective histories.

Directions for Work on Records

GENERAL:

Admission Slips—The nurse's slip should be retained in the ward for two weeks, in case it may be needed on account of loss of the original slip. At the end of the two weeks it may be destroyed.

FOR THE HOUSE OFFICER:

Appearance of Records—Handle records with care, that they may be kept free from blots and smooches.

Autopsies—In cases of death, state at end of history whether or not there was an autopsy. In the former case, write number of autopsy on chart sheet against heading "Path. No."; in the latter case, write at the end of the history "No autopsy."

Binding Line—Observe the words "Binding Line," and begin records on the right side of the paper, and do not write over this line.

Laboratory notes, bacteriological reports, x-ray findings, etc., write on Form 354.

Diagnosis, Final—Write in red ink on chart sheet, using nomenclature contained in the "Classification of Diseases," and writing corresponding number after the diagnosis. Do not give the name of operation in place of diagnosis.

Disposition of Records—Records of patients discharged during a day are to be handed in by head nurses of wards between 6:30 and 8:00 p. m. of that day. It is expected that they will be complete at this time. These histories will be kept on file in the record vault, and may be borrowed in accordance with the rules.

Re-Entries—Give re-entry references by hospital number, except in case of old references before hospital numbers were used on the records. In these cases, references should be by volume and page.

Transfers—The record of a case transferred from one service to another shall be sent *in toto* to the new service to be continued on such service and handed in, upon discharge of patient, with other records of such service.

For the Nurse:

Discharges—When a patient is discharged, write note to this effect in black ink across chart under proper date, and give place to which patient was discharged. If patient died, state this fact and specify exact time of death, in writing the discharge.

Medication—Write on Form 353.

Mending of Torn Charts—Charts which get torn should be brought to the record room, where they can be mended with proper material. Make no attempt to mend them in the ward.

Temperature, Pulse, and Respiration—Temperature, pulse, and respiration taken in the emergency ward in all cases later admitted to the house, must be recorded at the bottom of the admission slip, which is sent to the ward with the patient. The head nurse in the ward will see that this record of temperature, pulse, and respiration is placed on the chart of the patient as the first record.

Transfers—A transfer from one ward to another on the same service, or from one service to another service, should always be plainly noted in red ink on the chart before it is sent on to the new ward. In both instances, the entire record, including all accessory papers, should be transferred.

Duties of the Record Librarian

In brief, the duties of the record librarian are to see that a complete and satisfactory record of every patient discharged from the hospital is promptly handed in; that this record is catalogued by diagnosis, by operation, and by name, and filed; and that in due time it is bound. She must also see that at any and all times, except during the short period at the bindery, such record is accessible to those persons who are at liberty to consult it. She must carefully guard all records, allowing them to be consulted by no stranger or outsider, unless such request comes in the form of a written order signed by the resident physician, or one of his assistants.

It is necessary that there should be kept in the record room a list of the names of all patients in the hospital, and that note of their subsequent discharge should be made. These data are kept in long, narrow books (thin cash books are excellent for this purpose) known as the "lists," and they form the most important adjunct to the work; in fact, nothing could be done without them.

The "lists" are made up from the entrance-book every day, and are for the use of the record room clerks only. Each hospital service is kept in a column by itself. (Fig. 3 shows partial lists of two of the surgical services.)

For reasons which will later develop, it is convenient to have each day's admissions dated. The numbers are the hospital numbers. It will be noticed that while in each column these follow in numerical succession, there are missing numbers; e. g., 176020 and 176021 are East Surgical, while 176022 is West Surgical, and 176023 and 176026 do not appear at all, as they belong to patients on the medical service. Ellis is referred to as East Surgical No. 176020, and can by no chance be confused with any other patient, as no other, on any service, will ever have this number. Now take O'Connor on the West list. It has been found that he needs medical treatment, and consequently has been transferred to the West Medical Service. How does the record librarian know of this? By means of a transfer slip which is made out in all such instances, and which, when it has served its purpose in other parts of the hospital, is finally (within twenty-four hours) sent to the record room. It states that O'Connor, a West Surgical patient, has been seen by the visiting physician of the West Surgical Service, and is ready to be transferred. The librarian looks up O'Connor on the West Surgical list and writes above the name in red ink "to W. M.," giving also the date of transfer, and crossing the name off this list. His name will now appear on the West Medical list bearing this same number, and entered on that list in its proper place according to this number, i. e., it will be written between lines, and after it will be written "fr. W. S.," with date of transfer. O'Connor's West Surgical record will now be sent to the West Medical ward, where it will be continued upon the same sheets. When he is discharged from the West Medical Service the entire record will be handed in by this service. Now take Casey, East Surgical No. 176024: she entered as an East Medical case, and has been transferred to East Surgical. This illustrates the interlining. The eye of the librarian is immediately attracted to the transferred cases by the fact that they are written between lines, and that they are always written in red ink, while the rest are written in black, and she must be particularly careful in

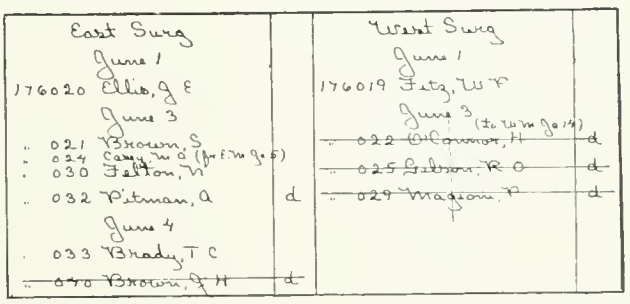


Fig. 3. The Lists.

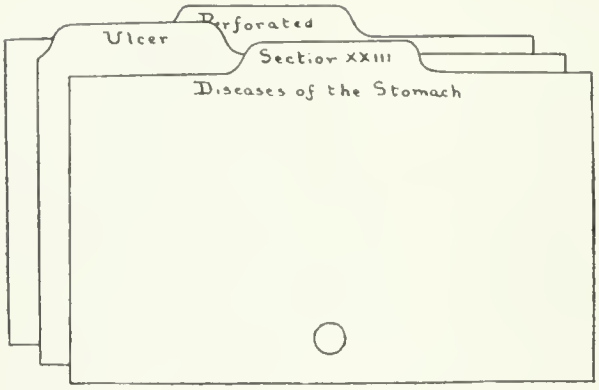


Fig. 4. Guides.

inspection to see that all sheets from both services are handed in, and that the proper notes of transfer have been made. One clerk of the record room has the "lists" in her care, and it is her duty every day to enter upon them, in their proper columns, the names of all patients admitted upon the previous day.

When a patient is discharged his "bedside card" (a card made out at the time of his admission and sent to his ward) comes to the admission office with notes upon it concerning his discharge. These notes are recorded in the entrance-book, and the cards are then sent to the record room as "discharge cards." From these "discharge cards" the librarian gets the names of patients discharged the previous day, and against these names on their several lists places a "d" in the narrow column; e. g., she finds that Annie Pitman, an East Surgical case entered June 2, is gone. She looks up June 2 on the East Surgical list, finds the name, and the "d" is affixed. If a patient entered in April and is discharged in June, it is, of course, necessary to look several pages back to find him. The "discharge cards" are filed away in chronological order for use in the follow-up work, later described.

(To be continued)

TRUSTEES INVITE SUGGESTIONS RELATIVE TO WORK OF ASSOCIATION

During the forthcoming meeting of the American Hospital Association, its trustees plan to hold a meeting for the specific purpose of receiving and considering suggestions from members of the Association relative to its work and progress.

Any members who may have suggestions to offer which, in their judgment, would improve the work of the Association or enlarge its services to the hospital field, are earnestly requested to submit these suggestions in writing, if possible, for the trustees on this occasion.

As the Association is anxious to be of the utmost service to its members, these suggestions will receive a sympathetic hearing and, if found praacticable, will be acted upon favorably.

The time and place of this meeting will be announced at the Convention.

TRUSTEES OF A. H. A. ADOPT IMPORTANT RESOLUTIONS

The following bulletin was recently sent out by the American Hospital Association to its institutional members:

The trustees of the Association have recently, after mature consideration, passed the three following resolutions which have direct bearing on fundamental hospital policies. We ask that you give to them careful consideration and determine what your institution can do in these fields to better hospital service to the public.

(1) WHEREAS, It is universally agreed that a determination of the cause of death by autopsy contributes greatly to the advancement of medical science, is of advantage in the accurate compilation of vital statistics, and, in a large number of cases, is extremely advantageous to the family of the patient for the protection of social rights and for hygienic purposes, and that the practice of routinely securing autopsies invariably results in bettering the medical work of the hospital; and
WHEREAS, The percentage of autopsies secured in many hospitals is so far below others that it can be explained only by indifference or neglect; be it
RESOLVED, That the trustees of the American Hospital Association do urge upon the Association, as a body, upon each member individually, and upon hospitals in general, the necessity for diligent action on the part of physicians and surgeons practicing in hospitals to make every effort to secure the performance of autopsies in all cases of death in the hospital, and that hospital executives be held responsible for securing the performance of an adequate number of autopsies in their institutions, in order to insure the maximum benefit in the medical work of the institution.

(2) WHEREAS, In the past, not all general hospitals have accepted tuberculosis; and
WHEREAS, It has been demonstrated in a number of such institutions that this class of case may be admitted into separate wards without detriment to other patients; and
WHEREAS, Both for humanitarian reasons and for purposes of instruction, there is need for a change of policy in this regard; then be it
RESOLVED, That the trustees of the American Hospital Association recommend to the American Hospital Association that it pass a resolution to the effect that it recommend to the hospitals that separate wards be established in general hospitals, where possible, for the care of such patients.

(3) WHEREAS, It is now generally agreed that only a small percentage of venereal disease patients need bed treatment at any stage of their disease; and
WHEREAS, It is now established that bed treatment for the few who do need it is of short duration and benefits not only the patient but distinctly lessens a public health menace; and
WHEREAS, Knowledge of venereal disease is now so general that the psychology of all attendants can be depended upon to prevent contagion from all known cases of venereal disease; be it therefore
RESOLVED, That we, the trustees of the American Hospital Association do hereby urge all hospital authorities to give consideration to this matter—to the end that all general hospitals shall admit venereal disease patients as other patients, and enter these diagnoses as other diagnoses on histories whether primary or complicating, and also develop sufficient dispensary service to provide care for the ambulatory cases and the ambulatory stages of the cases treated in the hospital.

There has long been the general opinion that it was always for the best interest of the hospital for the superintendent to attend all routine meetings of the trustees and that this is based on established principles of organization. At the annual conference last year approval of this was unanimously passed as a resolution of the Association. Attention, is, therefore, called to this with the hope that the trustees of any hospital wherein it is not the custom will give thought to the principles involved and institute the custom.

SELECTING MEAT FOR THE HOSPITAL

By HERBERT O. COLLINS, M.D., Director of Hospitals for Fresno County, Cal.

In the average American dietary meat and poultry supply sixteen per cent of the total food, from which is obtained thirty per cent of the protein and fifty-nine per cent of the total fat consumed. When we consider that meat is also one of the highest priced of our commoner foods, the importance of its careful selection and conservation is apparent and needs no emphasis. Great technical knowledge is not necessary; anyone can acquire the practical skill to be a good judge of meat. There are certain signs such as color, odor, resistance, general appearance, and taste, which one can learn to know and apply. Canned meats put out by good firms are reliable.

WHILE it is not within the province of this series of articles to discuss purely dietetic questions or food values, it is necessary for us to appreciate the relative importance of meat in our diets in order that we may give their intelligent selection and preservation the attention they deserve.

The value of meat in our food depends chiefly upon two elements, viz.: protein and fats. According to an investigation conducted recently by the Department of Agriculture, regarding the kind of foods used chiefly in American homes, in the average American dietary meat and poultry supply sixteen per cent of the total food, from which is obtained thirty per cent of the protein and fifty-nine per cent of the total fat consumed. When we consider, in addition, that meat is one of the highest priced of our commoner foods, the importance of its careful selection and conservation becomes apparent.

While the figures of the Department of Agriculture refer chiefly to meats used in American homes, they will apply equally to the feeding of the hospital employees, and with some modification to the dietary of the hospital patients.

Whenever possible, the meat for the hospital should be personally selected by some one experienced in judging its condition and quality. Whether it should be purchased in large or small quantities, by the selection of special cuts or in the whole carcass, or in halves or quarters, will naturally depend upon the size of the hospital and the facilities of the local market. Most large hospitals buy one or more whole or half carcasses at a time, often by contract, while many of the smaller institutions find some advantage in ordering the particular cuts needed from day to day, believing that the higher prices paid are justified by the lessening of waste and by the possibility of increasing the variety of the meats served. But with proper regard to the utilization of waste in the various ways known to the competent hospital dietitian, or even to the practical and conscientious cook, most hospitals, even though small, will find a saving if beef, at least, is bought in quarters or halves, providing there are proper storage conditions.

Great technical knowledge is not necessary for the proper selection of meat, as any person of intelligence can acquire the practical skill needed, especially if certain fundamental points are remembered. The general appearance and consistency will differ with various kinds of meat, and some experience in judging will be of value here.

Putrefaction, if it exists, will general be found beginning on the surface, from which it extends toward the inner portions by following the lines of the connective tissue and bones. When there is any suspicion of this nature it is well to note carefully the odor and appearance surrounding the deeper bony parts. A "tester" is sometimes used for this purpose. This consists simply of a long and stout needle or slender rod, usually mounted on a handle, which is thrust into the interior of the meat, especially about the bones, and its odor noted on withdrawal. In common practice this is seldom needed, except when buying hams, when it is quite useful. The condition of the blood vessels should be especially noted, as they should be practically empty, indicating that the animal was well bled at the time of slaughter. Meat from imperfectly bled animals is much more likely to putrify early.

In examining meat for evidence of putrefaction it should be borne in mind that bad odors are not always present, and therefore the odor of the meat alone cannot be relied upon as a safe test of its condition. This refers especially to putrid meat sausages, and salted meat. Nor are marked changes in color, as to gray or green, always characteristic. Changes in color, odor, resistence, general appearance, and taste will all need to be taken into consideration. When the question of putrefaction of the meat may be considered in court, where positive proof may be called for, as when the cancellation of a contract is involved, it is best to send sealed samples to

*This is the sixth of a series of articles by Dr. Collins on the hospital food service which is appearing in The Modern Hospital.

the laboratory for bacterial examination. For ordinary purposes any considerable degree of putrefaction is easily discovered.

Picking Out Good Beef

Good beef should be of a bright red color on its cut surface, rather firm in texture and shiny. A slight change to a darker color or even to a grayish color, where the surface has been exposed to the air, is of little significance, unless it is very well marked and extends deep into the body of the piece. The appearance of the fat is important and will differ somewhat according to the age of the animal, and the conditions under which it has been prepared for the market. Thus, in fattened steers, up to five or six years of age, the lean meat will be bright, and of a dark brick-red color, tolerably firm in texture, the cut surface showing a mottled appearance due to a mixture of fat with the muscle fibers. The fat itself will usually be firm, and of a white or light yellow color. An intense yellow color however, may be found in the fat of pasture fed cattle, and should not be considered a detriment. In older cattle, the fat is likely to be of a darker yellow color and of a softer consistency. The meat of fattened young cows, up to six or seven years, is very similar to that of fattened young steers, while that of older milch cows is of a lighter color and coarser fiber, the fat being of a lemon yellow color and less firm in texture. The meat of young fattened bulls is similar to that of steers, but that of old bulls is of a copper-red color, tough, dry, and poor in fat. In older cattle of all kinds the cuts from near the surface, or from those parts of the animal getting the most exercise in life, such as the legs, flanks and round, will be found more tough than the deeper ones.

The general appearance of veal and pork is sufficiently familiar to readers to require no discussion, but the judging of the fitness of poultry will require a little more experience. If kept in storage for any length of time the poultry should be drawn. The age of the fowl can be tolerably well determined by the housewife's familiar test of the toughness of the breast bone, which will break or bend easily in a young bird. The same condition will be found in the bones of the pelvis.

Fresh fish show a redness of the gills, and the eyes are clear and shiny. Later, the gills become more pale and the eyes are sunken and covered with a film. If the fish has been kept for some time, the scales, instead of being tight, can easily be scraped from the skin. A fresh fish should lie flat and stiff when placed across the hand, while the tail of a stale one will drop downward under such a test. If placed in a tub of water fresh fish sink below the surface, while stale fish float.

Substitution of one kind of meat for another is not common in this country, but is practiced at times by unscrupulous merchants. The slaughter of horses is so seldom done in America that the danger of the substitution of horse meat for beef need give us little concern. When suspected, it should be remembered that horse meat is of a dark red color, and when it has been exposed to the air it has a bluish luster, or may become a blackish-red color. There is no intermixing of fat with the muscle fiber, as in beef, and the fat, where it occurs, is soft and oily, of either a light gold or dark yellow color.

Goat meat is sometimes offered as mutton. When seen in the carcass, it will be noted that the sheep has a rounded back and is fleshy around the croup, while the goat has a sharp back and a sloping croup. The thorax of the sheep is round or barrel shaped; that of the goat is flat. In the goat the external lachrymal notch is absent, but is present in the sheep. Goat meat is paler than that of the sheep.

Chopped Meat Best Prepared at Home

Chopped meat (hamburger) is best prepared at home, otherwise one can hardly be certain of its composition or the condition of the meat which has been used, as the temptation is great to work up scraps of meat, otherwise unsalable, into this form. When it is prepared for the market it usually contains beef and pork, and ocasionally small quantities of veal. The short tendinous meat of the head, leg, and all other parts of the body are often added, as well as the fat. Sulphurous acid and its salts are often used, sometimes to an injurious extent, to cause it to retain its bright red, fresh looking, color.

Sausages, as found on the market, are made chiefly of muscle meat and fat, but blood, heart, tongue, scraps of connective tissue, hog skin, liver and various other parts of viscera are often added, with the necessary spices. The coverings are most commonly made of the intestines, but the esophagus, stomach, and urinary bladder of hogs are often used for such purposes.

Spoiled sausages usually have a smeary appearance, and often show a cyst formation under the casing. Those most familiar with the method of manufacture of sausages are least given to eating them, unless certain that they have been conscientiously made.

Canned Meats All Right

Canned meats, when put up by a reliable firm with a reputation to preserve, form a perfectly good addition to the dietary under certain conditions. They are most useful when good fresh meats cannot be obtained. For this reason there

is little excuse for their extensive use in the average American hospital, if we except certain varieties of canned fish or soup.

Cans of meat, if used at all, should be carefully examined before opening. Swelling of the cans, indicating the formation of gas and loss of the original vacuum, may be safely considered as cause for its rejection, and any can, the contents of which can be shaken before opening, due to liquefaction of the gelatine, should be considered spoiled.

When meat is to be kept for any time it is best preserved in an atmosphere of dry cold, a temperature of 40°F. to 45°F. being most suitable for this purpose. The storage rooms should be equipped with metallic racks upon which the meat can be hung, the general plans having been treated in a former article of this series. If properly stored, meat so kept becomes more tender and will have a more delicate flavor. The action of the cold is to check the causes of putrefaction but without entirely destroying them. Meat which is at all diseased will not be rendered more safe for food by cold storage, as many pathogenic bacteria are unaffected, even by freezing.

It is desirable to avoid all foreign odors in the room, as they may be absorbed, and affect the taste of the meat. For this reason, fresh game, fish, and poultry should not be kept in the same storage room as fresh meat. The odors from carbolic acid, chlorine, turpentine, tar, and tobacco are very easily absorbed by meat and should be especially avoided in the storage rooms. They may not be detected in the meat till after cooking.

The meat should not be laid directly on the ice, as an undesirable amount of moisture will be absorbed, and there is also danger of its becoming contaminated from bacteria and other foreign material contained in the ice.

May Be Contaminated in Storage

Meat while in storage, especially when improperly protected, may become contaminated by insects or their larvae. The flesh fly, or meat fly, is about one half an inch long, and much resembles the ordinary house fly in its appearace and markings. The blow-fly or blue-bottle fly is about four times the size of the house-fly. Its eggs are laid on the meat and in a few hours they hatch into the maggots sometimes found on decomposing flesh. The common house fly does no damage except through the filth it usually carries with it, and which makes it a real and serious danger.

The skipper is a small fly of a glistening black color, chiefly attracted to smoked meats and cheese, and consequently is sometimes known as the ham-skipper. The eggs quickly hatch into small maggots, whose ability to jump several inches gives them their familiar name. Rooms once infected are very difficult to clean, as the skipper jumps from one article of food to another. All meat or cheese found infected should be wrapped in cloths to prevent this, then carried out carefully and burned, and the room thoroughly cleaned before being used again.

Cockroaches, if allowed to infect the storage rooms, will contaminate the meat beyond the possibility of saving it.

Meat poisoning may result from either the chemical substances produced by micro-organisms (toxins) or by the bacteria themselves, or by both. The symptoms generally appear soon after eating the meat, although they may be delayed for several days, and consist chiefly of gastro-intestinal disturbances. Septic and pyemic affections in the animal are the most frequent causes, and it should be remembered that the degree of decomposition of the meat has no relation to its poisonous qualities, as slight decomposition may be followed by very severe poisonous symptoms in those who have eaten the meat. Once present, the poisonous substances may increase if the meat is not properly cooled in storage. Cooking kills the bacteria present, but has little or no effect on the toxine. For this reason, meat eaten raw, or slightly cooked, is the most dangerous. Such organs as the liver and kidneys may be poisonous while the rest of the meat is harmless. Poisoning by fish or oysters is usually of a bacterial nature. The chief safety against all forms of meat poisoning lies in careful inspection of the food animal before slaughtering. Chopped meat (hamburger) is especially dangerous, unless prepared in the hospital from meat known to be in good condition.

EXHIBIT AND INFORMATION SERVICE ON HOSPITAL SOCIAL WORK

The Service Bureau on Hospital Social Work of the American Hospital Association will conduct an information service during the meetings of the Association in September. Special appointments can be arranged for those who care to discuss any phase of hospital social work with experienced workers.

An exhibit showing the function, organization, and extent of hospital social service in this country is being assembled for the meeting. Samples of records, statistics, forms, and special literature will be available for those who care to see them.

Miss Ida M. Cannon, the chief of the Bureau, is hoping that the hospital administrators and trustees will take this opportunity to let the Bureau serve them. The Bureau headquarters will also be the headquarters of the American Association of Hospital Social Workers, who will hold their semi-annual meeting at this time.

Science is . . . like virtue, its own exceeding great reward.—Kingsley.

COSTS IN THE HOSPITAL LAUNDRY*

By WALTER TRIMBLE, Chicago, Ill.

THIS article is written more as an attempt to show the desirability of a uniform cost determining system in the hospital laundry in general, than to give any actual cost comparisons. There are many cost factors besides labor expense and the cost of washroom supplies, the only ones which are brought out at this time, but nevertheless I believe that the analytical reader will be able to glean at least a little valuable information from the figures which I will present.

Some of the more progressive commercial laundries have a uniform cost determining system, furnished by their national organization, by which actual costs of production, all determined on the same basis, can be compared and checked up by the respective laundry operators, each with the others. This is a very valuable guide, as it shows the relative efficiency of a plant. Doubtless this system of cost finding could be so modified as to answer the purpose of the hospital laundry.

The comparisons which I submit herewith are from figures that were kindly furnished by the managers of two hospital laundries, one of which is rather a large institution, the other being relatively small. These are the Presbyterian Hospital, of Chicago, and St. Luke's Hospital, of St. Paul.

The Presbyterian Hospital occupies an entire city block, has accommodations for 425 patients and receives over 10,000 per year. There are twenty-four house physicians, 300 graduate and student nurses and 300 general employees. The hospital maintains a home for its nurses, and there are thirty maids employed in it, to take care of its 250 rooms.

Hospital Superintendent Asa S. Bacon, who has been the directing head of the entire institution for eighteen years, takes great pride in its efficient laundry department, which is ably man-

*This is the ninth of a series of articles by Mr. Trimble on the hospital laundry, which is appearing in THE MODERN HOSPITAL.

WASHROOM OF PRESBYTERIAN HOSPITAL LAUNDRY

The washroom equipment consists of four large metallic washers, four extractors and the usual accessories. It will be noted that a very large amount of work is turned out in a very small amount of space.

HAND IRONING DEPARTMENT OF PRESBYTERIAN HOSPITAL LAUNDRY

The hand ironing department is located in the center of the east side of the room. Beyond it, in the corner, is the collar finishing department. At the right are two tandem sets of small pressing machines, or four in all. The man at the left is Manager Jones.

aged by B. H. Jones. This department is a model in every way. It is the last word in cleanliness and neatness, and it is flooded with sunlight, which enters from its many windows on the east, south, and west side. The ventilation is perfect, and thus the working conditions are ideal.

Under the administration of Superintendent Bacon, the Presbyterian Hospital has been recognized as one of the finest, most complete, and most efficient in the country. Manager Jones has been in charge of the hospital's laundry for eight years, and some of the workers have been with him for almost as long a time. There are thirty workers in the laundry, and that the force is an exceptional one may well be seen from the bright faces in the accompanying illustrations.

St. Luke's Hospital, although a smaller one, is no less complete and efficient, and it has a laundry department which may well be taken as a model. The superintendent of this hospital is Miss Adah H. Patterson, and its laundry is managed by Arthur W. Green. The institution has eighty-nine private rooms and sixty-two beds in wards, making normal accommodations for 151 patients, although this number sometimes is exceeded. There are fifty nurses and twenty-five general employees.

The hospital's laundry is housed in a separate two-story building, each floor of which is twenty-five by thirty feet in size, and ample light and ventilation are afforded by twenty-four large windows. The equipment consists of two thirty-six by seventy inch brass cylinder washers, two extractors, one four-roll flat work ironer, one drying tumbler, two pressing machines and the necessary incidental appliances. It does not launder starched collars. The work is done by the superintendent and six female workers.

The following table shows the amount of flat work which each laundry does in an average week for the hospital proper. The larger hospital uses an average of about 130 pieces per patient per week, while the smaller uses an average of about 100. Each hospital, it will be noted, uses about twelve sheets and twelve pillowslips per patient per week, and each uses about six spreads per patient per week, which indicates that the main items run pretty close together.

HOSPITAL FLAT WORK

	Large Hospital	Small Hospital
Sheets	5,084	1,906
Spreads	2,693	908
Pillowslips	5,034	1,807
Hand towels	5,415	2,019
Bath towels	2,364	972
Tray covers	5,697	950
Supply room linen	6,780	500
Dish towels	2,173	304

LARGE PRESSING MACHINES IN PRESBYTERIAN HOSPITAL LAUNDRY

The above view shows a large pressing machine unit, it being located in the center of the north side of the room. At the right is the shirt ironer, and beyond this is the collar-finishing department.

	Large Hospital	Small Hospital
Napkins	2,496	725
Wash cloths	664	175
Diapers	2,580	908
Glass towels	1,875	....
Binders	183	120
Children's gowns	634	....
Individual towels	2,797	300
Bed pan covers	2,301	241
Operating gowns	913	182
Tablecloths	120	35
Bags	1,660	....
Roller towels	165	23
Bed pads	246	71
Bath rugs	116	4
Broom covers	83	....
Mattress covers	74	....
Kitchen aprons	170	30
Kitchen towels	460	....
Children's bibs	46	....
Aprons	238	42
Pillow covers	42	....
Children's aprons	48	....
Dresser covers	55	361
Operating bags	15	13
Chair covers	15	....
Operating caps	161	54
Mattress pads	75	....
Iron holders	27	9
Gowns	1,150	228
Rags	1,260	1,680
Total pieces	55,909	14,567

The reader may readily make his own comparisons of the work done for the nurses of the respective hospitals from the following tables, remembering that the large one has 300 and the small one fifty:

NURSES' HOME FLAT WORK

	Large Hospital	Small Hospital
Sheets	292	150
Spreads	127	63
Pillowslips	293	123
Hand towels	995	321
Individual towels	227	47
Dish towels	132	....
Dresser covers	280	58
Napkins	296	216
Tablecloths	63	....
Blankets	17	20
Bath rugs	23	2
Bread cloths	2	....
Table strips	4	....
Pads	4	2
Total pieces	2,755	1,002

NURSES' HOME INDIVIDUAL WORK

	Large Hospital	Small Hospital
Aprons	1,120	284
Apron bibs	870	277
Cuffs	1,393	510
Collars	382	....
Handkerchiefs	1,034	45

	Large Hospital	Small Hospital
Caps	201	32
Nightgowns	202	25
Chemise	460	25
Corset covers	98	5
Drawers	25	3
Stockings, pairs	58	2
Underskirts	131	7
Underwear	148	20
Shirtwaists	51	....
Wrappers	12	....
Uniform dresses	214	53
Curtains	179	....
Pajama suits	5	....
Individual towels	66	....
Wash cloths	131	....
Dresser covers	4	....
Total pieces	6,784	1,288

Summary of Work Done

Besides the foregoing items, each laundry did considerable miscellaneous work which it is not possible to itemize at this time, but the following statements give the total weekly work done by each plant under normal conditions. The prices are based on commercial laundry rates in the respective cities.

THE LARGE HOSPITAL

55,909 pieces of hospital flat work	$1,650.00
1,272 curtains and blankets	245.00
3,454 pieces of bundle work	664.00
2,755 pieces of nurses' home flat work	82.65
6,784 pieces of nurses' home starched work	809.72
Total charge for week	$3,451.37

The productive payroll for this week was $491, or about fifteen per cent, and the cost of supplies was $125, or a little less than four per cent. This is a remarkably good showing.

THE SMALL HOSPITAL

14,917 pieces of flat work (4,468 pounds)	$ 446.80
72 curtains	18.00
204 blankets	51.00
1,303 pieces nurses' personal work	166.62
295 pieces officers' personal work	75.16
174 pieces employees' work	28.35
Total charge for week	$ 785.93

The wages paid for this week to the manager and six female workers amounted to $114, which makes the productive payroll a little less than 20 per cent. The manager is included, because he helps to do the work. The cost for washroom supplies for the week was $16, or a little less than two per cent.

All of the foregoing seems to indicate that it is possible to operate a small hospital laundry on practically as efficient a basis as a large one. Of course there are other expenses than productive labor costs and the cost of washroom supplies, as

FLAT WORK IRONER IN THE PRESBYTERIAN HOSPITAL LAUNDRY

This large machine is placed in the center of the room, and it receives plenty of light from three sides. Its normal speed is about seventy-five feet a minute, which means the ironing of about twelve sheets per minute.

LINEN ROOM IN PRESBYTERIAN HOSPITAL LAUNDRY

In this room all of the work is assembled for delivery to the various departments in which it belongs. At the north end of this room is located the marking department for bundle work, the assorting bins, the wrapping tables, and other accessories.

I have pointed out, hence, the reader should not confuse these figures with net, or actual, costs of laundering.

REPRESENTATIVES FROM BRUSSELS VISIT AMERICA

Two representatives from the city of Brussels, Mr. H. Goosens-Bara of the public hospital board, and Mr. J. B. Dewin, architect, who came to the United States in connection with a plan for the development of facilities for medical education in Brussels, to which the Rockefeller Foundation is giving financial assistance, arrived in New York in July.

Mr. Goosens-Bara, who comes as the official delegate from the hospital board of the City of Brussels, is a prominent lawyer and public spirited citizen, serving as a member of the unpaid board which administers the hospitals and dispensaries of Brussels. His object in visiting the United States is to familiarize himself with hospital administration in this country.

Mr. J. B. Dewin, the other visitor, has been appointed by the City of Brussels as architect for the new hospital of St. Pierre, a public hospital to be used as the teaching hospital of the medical school of the University of Brussels. He has also been appointed architect of the laboratories to be built on the same site. Dr. Dewin has built the Cavell-Depage nurses' training building in Brussels, and the Red Cross hospital and clinic, as well as a number of private clinics for leading medical and surgical men in Brussels. He comes to this country to study recent types of medical laboratory and hospital construction before developing his own plans.

The Rockefeller Foundation is contributing more than $3,000,000 for new buildings and endowments for the medical school of the University of Brussels. The laboratories and class rooms of the medical school will be entirely rebuilt and redeveloped on a new site adjoining that of the municipal hospital of St. Pierre, which is also to be rebuilt and reorganized. The new hospital will contain 350 beds, with a well equipped out-patient department, laboratories, and accommodations for teaching and research.

As a part of the general plan, a nurses' training school is being established in memory of Edith Cavell and Mme. Depage, who lost her life in the sinking of the Lusitania when returning from America after soliciting funds for war work.

These two distinguished visitors are coming to this country as the guests of the Rockefeller Foundation. On their way back to Belgium Mr. Goosens-Bara and Mr. Dewin will also visit hospitals and medical laboratories in Great Britain.

PHYSICIANS TAKE DAY AND A HALF

The keeping of medical men on duty twenty-four hours a day seven days a week is solved in Chatham, Ont., by a very simple arrangement. There is a local medical society and the members have pledged themselves to take Thursday afternoon and Sunday off. Four are then selected to remain on duty. These four take all calls which come in, make their own charges, and turn the patient over the next day to his regular physician. In each doctor's office is a printed card which is placed in the door. It states which men are on duty and where they may be found. The plan seems to be working well.

LAY CORNER STONE OF PRESBYTERIAN HOSPITAL OF COLORADO

Sunday, June 26, with the Rev. W. H. Wray Boyle, D.D., first vice-president of the association and pastor of Central Presbyterian Church, officiating, Governor Oliver H. Shoup laid the corner stone of the first building of the Presbyterian Hospital of Colorado.

Governor Shoup is president of the board of managers and has always taken a personal and leading interest in all that has been done in inaugurating the work of this institution.

Among the other speakers were: W. N. W. Blayney, vice-chairman of the building committee, who delivered the trowel to Governor Shoup; State Attorney-General Victor E. Keyes, Mayor Dewey H. Bailey of Denver, Frank N. Briggs, treasurer of the Hospital, and Martin J. O'Fallon, representing the Catholic brotherhood.

The services were short but very impressive, held as they were in full sight of the Rocky Mountain range, from Pikes Peak on the south to Long's Peak in Estes Park; an ideal site on which to erect such a comprehensive institution as this is to be.

The first building should be ready for patients by the first of January, 1922, and the entire first unit completed within two years.

The man with the trowel is Governor Oliver H. Shoup, the head appearing just at the right of the corner stone is Honorable Victor H. Keyes, state attorney general, next to him is the Reverend Mr. Francis Smiley, who represented the hospital at the General Assembly of the Presbyterian Churches in the United States, and the last one to the right is the Reverend W. H. Wray, D.D., first vice-president.

WEST BADEN AS A WAR EMERGENCY HOSPITAL

ALTHOUGH little by little the ravages of the World War are drifting into dim and uncertain memories of the past, none of the vast corps of men and women in the medical and surgical professions have forgotten the sudden and overwhelming need for hospital service that came in this country, as shipload after shipload of our boys, sick, shattered, weary in body and soul, were brought home from foreign battlefields. In this great emergency, West Baden Springs Hotel, the site selected for the convention of the American Hospital Association, next September, was viewed by the government as an ideal haven, with its splendid accommodations and its health giving waters. But in the wave of patriotism and of sacrifice which swept over the country at this time the same thought had come to the heads of the West Baden Springs Company, and, it is related, a representative of the company was on his way to Washington to tender the big hotel and its adjacent buildings and grounds to General Gorgas, then Surgeon General of the Army, when Brigadier General Robert E. Noble and his staff arrived at West Baden, in quest of the property. General Noble found ready response on the part of the management, and in a few days the deal was made, and the popular resort passed into the hands of Uncle Sam and the medical department of the United States Army.

*This is the second of a series of three articles on West Baden Springs. The series is published to give delegates of the American Hospital Association a background for their visit.

This was early in September, 1918. Many guests had come in for the fall season, and reservations for weeks ahead were piling up in the hotel office. But the course having been determined, no steps were taken half-heartedly. Notifications of the change in plans were immediately sent out. Patrons of the resort sighed, "It is too bad to give up this beautiful place, but how wonderful it will be for the boys." Before the end of the month, fun loving, happy hearted guests had given way to a corps of army men, concert and dance music had yielded to the resounding clamor of saw and hammer, and the work of reconstruction was well under way.

Men of recognized ability were placed in charge of the structural changes for the hospital, and they skillfully used or adapted every advantage of building and grounds. The rooms on the first floor of the main part of the hospital building were turned over to the business of the institution—offices of all heads of departments, supplies, visitors' parlors, receiving and consulting rooms. The main entrance was from the side. The massive entryway through the lobby was barred and the lobby itself was made into a ward containing sixty beds, while the writing rooms on either side took care of twenty-seven more.

A Christmas tree that reached to the fourth story, was part of the memorable Christmas celebration given for the pleasure of the soldiers at West Baden.

These rooms and the mezzanine floor above, which was similarly used, were shut off from the atrium and corridors by heavy glass doors. The inner court was a recreation room and a wonder-

ful moving picture theater. A rolled screen was used, which dropped down over two stories, and a powerful projector was placed in the parlors opposite, 200 feet away. There was always good music and the patients able to be up sat at ease around the tables and thoroughly enjoyed the show. Even those in bed in the inner rooms could see the pictures without so much as having to lift their heads.

The rooms on the second, third, fourth, and fifth floors were made into two-bed and three-bed rooms, one-quarter of the circle constituting a ward, with a head nurse in charge. Rooms "en suite" were made into nine-bed and eleven-bed special wards. There was a diet kitchen and utility room on every floor.

Half of the sixth floor was used for officers' quarters. In the other half were the offices of the physicians and surgeons, and the operating rooms. The dental surgeon, the eye specialist, the ear, nose, and throat specialist, the head surgeon, the laboratory and x-ray specialist, and the consulting physicians all had special departments, completely equipped. Operating rooms were made large and airy by the removal of partitions and the concrete walls and floors were snowy white.

The stately old dining room was transformed into a "messeteria." Do you get the full significance of that word? It may not be in the dictionary, but it has found its place in military parlance. Officers' mess was in the private dining rooms. In the main room there was a seating capacity of 662, and there were three mess calls for every meal. It was not likely that the quartermaster assigned there ever found time hanging heavy upon his hands.

All of the amusements provided on the grounds, bowling, billiards, horseback riding, tennis, golf, were turned over to the post exchange, which occupied a quarter section of the main floor. Moderate prices prevailed, but everything that brought in money was turned into a hospital fund that was used for patients and enlisted men.

The first arrivals at West Baden Hospital.

Every available building on the grounds was brought into service, and comfortable, cozy living quarters were made on the second and third floors of the garage, the second floor of the bathhouse, and in part of the natatorium. The buildings were heated and tubs and showers were put in. As rapidly as possible the six or seven farmhouses on the estate were taken over and put into military quarters. Accommodations were provided for 502 enlisted men.

Men picked for oversight of this work were men of ability in their lines. Colonel Raymond W. Bliss, commanding officer, was a recognized genius in organization. He is a graduate of Tufts College and of Tufts Medical School, and has been connected with the service since 1911. Before the war he was stationed in Arizona and in Honolulu. When Camp Wheeler, near Macon, Georgia, was built, he was sent to organize and maintain the base hospital there, which, under his charge, reached a high state of excellence.

Miss Alice Beatle, chief nurse, was one of the few persons in the world who saw the war from both sides. At the beginning of the great conflict she was placed in charge of the Red Cross Hospital at Budapest, where she remained until her own country needed her services. When that time came she was made head nurse in the base hospital at Camp Wheeler. From that post she was transferred to West Baden where she was in charge of 150 nurses on active duty, also at the head of the nurses' training school, to which an equal number of student nurses were assigned.

Major W. Hershey Thomas, of Philadelphia, formerly an associate professor in the University of Pennsylvania, was chief surgeon. Associated with him in this department was Major Charles E. Phillips, who had been in charge of the government hospital in Panama for the last twelve years. Captain J. A. MacDonald, of Indianapolis, was the head of the department of internal medicine. In both of these departments there was a large staff of assistants. In addition, Captain MacDonald had under him the directors of physical training.

Captain William M. Lewis, of Minneapolis, who at that time was regarded as one of the leading authorities in his specialty in Minnesota, was the eye specialist. Major Arthur Wheat of Manchester, N. H., was in charge of the x-ray examinations. He had only recently returned to this country after several years spent in missionary colleges in Turkey.

Captain Charles R. E. Buck, of Chicago, a Rush

Medical College man, treated diseases of the ear and throat. All orthopedic cases were placed under the care of Captain Joseph O'Dwyer, of New York, whose name is widely known through his father's invention of the O'Dwyer tube used in the treatment of diphtheria. Laboratory work was placed under the direction of Captain John F. Kenny, formerly instructor in the Tufts Medical School.

Lieutenant-Colonel Bliss, commanding officer, and his medical staff.

An elaborate educational course was at first planned for this institution, with the erection of two large buildings contemplated, but the signing of the armistice put an end to this part of the program. Colonel Bliss, however, had promised a selective course of training for the boys and he was determined that this promise should be made good. With the cooperation of Professor Roberts, of Purdue University, a volunteer faculty was organized, and all grade and high school subjects, music, art, and some vocational work were offered in the curriculum. Wives of the officers took charge of classes in reading, writing, and arithmetic, and even Latin and algebra. Through the Knights of Columbus and the Red Cross, others who were qualified to handle various scholastic branches were brought in. Boys who wished to study electrical appliances were allowed to work with the hotel electrician, practical gardening was open through work under the local gardner, and so through all available channels, a chance was offered to every lad who wished to make use of a real opportunity. Some of the larger rooms that could be spared were turned into class rooms, all the atrium parlors were used for groups in various lines of handicraft, and in the afternoons the teachers went into the wards and taught individually the patients who were not able to leave their beds.

The romantic and unusual setting presented in this great hospital made it the mecca for many organizations who felt that their work would appear to splendid advantage. Novel entertainments were staged, and elaborate scenic effects were carried out in full detail. Both, however, reached their climax on Christmas Day, when a real, live, honest to goodness circus was brought into the building, giving a performance in the great inner court now known as the Pompeian room. Not a thing was lacking. There were trained lions, performing elephants, bareback riders, the full quota of clowns, red lemonade, and all.

That was a Christmas that will never be forgotten. Two days before a huge tree had been brought in, the largest that could be found in Orange County. It was so tall that its topmost branch reached to the fourth floor, and so large that an entryway had to be cleared to bring it through. The decorations of both tree and room were very beautiful, hundreds of willing hands having contributed their work to the making and the hanging of them. With the first faint rays of the early dawn the chimes pealed out the Nativity. Carollers strolled through the great building, first in the lobby then in the great court, out upon the balconies, through the long corridors, telling in echoing cadence, the joyous story of the Christmas morn. After breakfast, gifts were dis-

A Sprudel cocktail, from Sprudel Spring at West Baden.

tributed, and friends were allowed a real visit. But it was after the Christmas dinner that the genuine excitement began. The John Robinson and Haganback-Wallace circuses both winter at West Baden, and through the forethought and generosity of Mr. Ballard, owner of the shows, and of Mr. and Mrs. Rexford, of the West Baden Springs Company, enough acts were brought in to make a program brim full of interest. A sawdust ring was put in over the marble floor, and every detail of a show under the "big top" was carried out as far as possible. It is safe to say that no performance was ever given before a more appreciative or more enthusiastic audience. Every boy who could be brought down to the main floor was allowed the privilege of joining the jolly groups there, but even the ones who could not leave their beds were transferred into the rooms that looked out upon the court, with their beds placed so that they could see and hear everything that was going on without lifting their heads from the pillows.

The welfare and the contentment of the boys who were assigned to this hospital is shown to excellent advantage in the records, in which there is not a death listed, and but two cases of absence without leave. This is a record which probably can not be excelled by any other hospital in the service.

As long as the need remained, West Baden was left in Uncle Sam's control. When the days of emergency were passed, the members of the West Baden Springs Company very cheerfully took up the stupendous task of piecing together the threads that had been broken, of establishing new business connections, and of reorganizing the large force needed, in order that the pleasure-bringing and health-giving career of the big resort might go on. The war history of this place is fast becoming one of the dim and uncertain memories of the past, save in one never to be forgotten aspect, the glad consciousness of a duty well and faithfully performed.

MISS EDNA G. HENRY RESIGNS

Miss Edna G. Henry, who has for several years been the director of the social service department of Indiana University's School of Medicine, has recently resigned. Her resignation, which was tendered in September, 1920, was not accepted until June, 1921, and became effective on August 1, 1921.

Mr. Robert E. Neff is the new director of the department. Miss Henry, however, will remain as associate professor and continue the teaching of social service students, giving special attention to the graduate and research work.

Mr. Neff is a business man and not a social worker or teacher. It is expected that under him will develop still further medical social work now being done in the Robert W. Long Hospital and in the Indianapolis City Dispensary, and the teaching, also new work in the proposed Children's Hospital, which is not yet built. The social training of student nurses and medical students will continue under the direction of Mr. Neff.

The department remains a separate department of the College of Liberal Arts of Indiana University.

SERVICE—THE CONVENTION'S WATCHWORD

At its West Baden Convention, the American Hospital Association will make unusual efforts to be of practical service to the delegates who are in attendance. Various bureaus, the details of which appear elsewhere in this issue, will be established and manned by thoroughly qualified persons who will be at the service of the delegates in solving any knotty problems which they may wish to bring.

An especial effort is being made to have the commercial exhibit highly educational in character, with a view to giving the delegates practical service along the line of hospital equipment and supplies, which cannot be secured in any other way.

NURSING BILL PASSES ASSEMBLY

A Nursing Education Bill which was introduced into the Wisconsin Senate on February 4, has recently been passed by the Assembly and is before the Governor for his signature. It was strongly opposed by the State Board of Medical Examiners, from under whose control the nurses were asking to be released. The educational qualifications have been fixed at one year high school and at least two years in an accredited school of nursing.

The Bill provides for: (1) The transfer of the nurses from the State Board of Medical Examiners to the State Board of Health; (2) A committee on nursing education; (3) An educational director; (4) Compulsory registration and re-registration every year; (5) Reciprocity.

DR. WARNER DELEGATE TO DIETETIC ASSOCIATION

At a recent meeting of the board of trustees of the American Hospital Association, Dr. A. R. Warner, executive secretary of the Association, was appointed as the official delegate of the Association to the next annual meeting of the American Dietetic Association, which is to be held in Chicago, October 24 to 26.

THE ANESTHETIST, MEDICAL MAN OF THE SURGICAL TEAM

By P. J. FLAGG, M.D., New York City

BEFORE the standardization of anesthesia can begin, the exact relationship of the anesthetist to the other members of the surgical team must be determined, and the scope of his activity must be defined. The necessary qualifications of the administrator of anesthetics will then become apparent.

Anesthesia may be described as the detailed medical treatment of the patient immediately before, during, and immediately following operation. The anesthetist is the medical man of the operative team. He represents, as it were, the general practitioner and the internist during the period of anesthesia. Armed with a critical and comprehensive physical examination and a carefully considered pre-operative diagnosis, he proceeds to bring to bear upon the patient his medical knowledge and practical experience in the choice and the administration of deadly drugs.

While the diet, particularly in institutional work, is in the hands of the surgeon or house man, yet there are phases of this question which must be understood and frequently directed by the anesthetist, as for example—the diet of the diabetic before operation, the duration of fasts, or the correct treatment of emergency cases who have had a recent meal.

In the light of the patient's existing physical condition and in view of the operation which must be suffered, the anesthetist prescribes the best drug or combination of drugs, their dosage, and the proper time of administration.

The Operative Period

Aware of the normal reaction to the drugs which he has administered and familiar with the signs of over and under-dosage, he then proceeds to select from his armamentarium the drug or combination of drugs which, when correctly administered, will bring about the degree of unconsciousness, abolition of pain and the muscular relaxation best suited to the operation in hand.

The following is an excerpt from a letter concerning Dr. Flagg's paper, from Dr. Charles H. Mayo, Mayo Clinic, Rochester, Minn., to whom the paper was sent for comment.—Editor.

I believe the point of view that the anesthetist should be a physician in order to be a good anesthetist and that he should be trained in only one line of anesthesia is not proved.

Today the nurse must be a high school graduate, and in many institutions a college course, or a two year university course, is required. She has four years of training and practical work, with very brief vacations each year. A lecture course in the fundamental branches of medicine is now given which is much better than that given in many of our medical colleges twenty-five years ago, and compares not unfavorably with that given in some of our medical colleges of today. In fact, the nurse has been trained not only to care for the individual patient, but also for groups of patients; she is now engaged in the care of groups of patients in hospitals, in public welfare and baby welfare work, in school and city nursing, and for surgical dressings in industrial institutions. A well trained nurse giving her time to the administration of anesthetics, with opportunity to practice the art, must be recognized as competent, and no good can come from belittling her knowledge and experience.

The choice of anesthesia for patients requiring special care should be made by the physician, who from his examination has identified the disease and the indications for operation. He should take the full responsibility; it should not be thrown on the anesthetist.

A physician who administers anesthesia should be conversant not only with all methods of administering inhalation anesthesia, but also with all procedures connected with local and regional anesthesia, including spinal anesthesia, in order that he may be able to change to any type as a means of accomplishing the work in hand.

About 60 per cent of the surgery in France is performed under regional or local anesthesia. Such methods of anesthesia can be handled only by those who possess a thorough knowledge of anatomy. There is probably no type of operation which cannot be performed under local or regional anesthesia. I believe that the next progressive step in surgery in America will be the development of methods of anesthesia to accomplish the surgical work indicated. It will thus not be necessary to prepare the patient for the anesthesia, but to adapt the anesthesia to the needs of the patient.

I would advise all young surgeons to perfect themselves in a knowledge of the anatomy of the human body, and in the administration of all types of anesthesia.

These drugs, nitrous oxid, nitrous oxid and ether, nitrous oxid and oxygen, chloroform, ethyl chlorid, etc., are administered continuously over a period determined by the operative procedure. The administration of the drugs employed to bring about the actual anesthetic state differs from the preliminary medication, in that the effects are more profound, more rapid, more deadly, and must be constantly repeated in order to maintain the desired state of unconsciousness and muscular relaxation. The amount of the drugs administered at each of these repeated doses is determined by the reaction of the patient to the dose which has immediately preceded. The existing condition of the patient is determined by the rate, the rhythm, and the amplitude of the respiration, the color, the relaxation of the muscular system, the reaction of the higher centers, which govern the respiration and the circulation, as expressed in the pupillary reactions, and finally, by the rate, rhythm, and amplitude of the pulse. These signs must be correctly interpreted not only as regards the normal reaction to the drug administered, but also in view of the latent effects of the preliminary medication and the immediate effects of the surgical procedure. These signs in the aggregate determine the subsequent dosage to be administered. A correct diagnosis must be made repeatedly, and this diagnosis can be made by the administrator alone. The operator, by virtue of his removal from the region where the signs are best studied, and because of his surgical activity, is unable to appreciate the patient's precise physical state at any given time. As a consequence he cannot direct the correct dosage required.

The administration of anesthetics is the most complex and the most dangerous field in therapeutics. The administration of opium is under legal control, and yet the administration of anesthetic drugs, capable of bringing about sudden death, is shielded by the fact that this administration is incidental to a surgical procedure. Deaths from over-dosage by anesthetic drugs are all too frequent when the best medical skill available is employed. How, then, can we look upon the operating team or the institution which entrusts the most dangerous department of its therapeutics to the non-professional members of its staff? To argue that anesthetics have been administered to thousands of cases by lay persons who have been specially trained to observe the phenomenon which occurs during the unconscious period, is no justification. It would be as easy, and often less dangerous, to allow the non-professional members of the staff to take out an appendix or to do a gastro-enterostomy, to put up fractures, or to prescribe strychnine or digitalis *ad lib.* Complications and deaths from anesthesia under lay administration are seldom reported as such. A death certificate made out as status lymphaticus, cardiac dilatation, shock due to hemorrhage, or the innumerable pathological conditions for which the patient may have suffered operation, easily obscures improper preliminary medication, faulty choice of anesthetic agents, faulty method of administration, a failure to meet complications, or over-dosage. This is not deliberate misrepresentation, but is due to the fact that the non-medical mind of the administrator is not capable of arriving at a comprehensive medical point of view of the patient at any given instant, that no amount of training in the mechanical act of dropping ether can replace the background afforded by four years of study in a medical college. This non-medical observer is blind to the exact meaning of the phenomena of which he is a witness. He is in no position to unravel the complications which may arise, for example: in a case where morphin depression, reflex inhibition, and acapnia occur together, the patient lives or dies in spite of him. And when death does occur, the phenomena which preceded its advent, not having been witnessed by medical eyes, are consequently not available for record, and the responsibility is put upon the broad shoulders of the surgical condition of the patient.

After the Operation

The anesthetist, the medical man of the surgical team, has been a constant and a close observer of the physical condition of the patient since he has been under his care. He has become familiar with his peculiar reaction to the various drugs which he has employed. It is his duty to close his services by directing the position which the patient should assume, to prescribe the nature and variety of the stimulation indicated, and in view of the patient's reaction, to limit the post-operative sedatives employed.

As we consider the obligations of the anesthetist, we must conclude that his work is critical, dangerous, and on a par with the operation itself, that it is a physical impossibility for any but a trained medical mind to grasp these obligations and properly fulfill them, that there is a distinct moral obligation placed upon the institution and the surgical team to safeguard the life of the patient by every means under its control. This can only be done by refusing to tolerate a system which allows a non-medical person to administer deadly drugs at his discretion. No question of expediency, economy, or shorthandedness can absolve us from this responsibility, and the matter of military emergency no longer exists.

The standardization of anesthesia cannot prop-

erly be begun until its exact nature is generally understood, and it is placed in the hands of a strictly medical personnel.

The number of available interns is small, and among these there is even a smaller number who are of the particular mechanical turn of mind which makes good anesthetists.

The number of available nurses is large, and among these many are of a mechanical turn of mind. They are inexpensive, will stay on service for a long time, if well treated, and can be taught to put patients to sleep and keep them fairly quiet. They can match up to the house doctors pretty well in their externals. To select the latter course is to simplify the anesthetic situation for the institution, and in part for the surgeon.

Justice to the patient, however, and reason, indicate the vicious effect of thus secularizing medicine, and forbid our acceptance of this "easier way."

As will be perceived by the foregoing, anesthesia is a complex branch of the practice of medicine. It may be possible for a lay person to perform the mechanical act of administration by long practice, but such an administrator can never teach the art of anesthesia, for teaching implies an intimate medical knowledge of the physical reaction of the patient. No self respecting medical student will permit himself to become the pupil of a non-medical person, who may presume to teach what he knows of the art of anesthesia.

So we are led to the conclusion that the ultimate result of such a practice is the decadence of one of the most beneficial branches of the practice of medicine.

Interns Should Be Able to Teach

Owing to the hesitation of some institutions to accord anesthesia the dignity which it deserves, many interns now in practice are incapable of administering anesthetics correctly by the more simple methods. These men have been a twofold loss to the community, for in addition to understanding how to administer an anesthetic, they should be able to pass this knowledge along to others.

The standardization of anesthesia is therefore hampered at the outset by a scarcity of medical men capable of teaching those who are now being educated in the medical schools and hospitals throughout the land.

To meet this emergency our attention should be directed first to the intern, now at work in our hospitals. He should be taught to appreciate the critical nature and the dignity of this work, and he should be required to administer all anesthetics for which the institution is responsible. He should be impressed with the fact that the anesthetics which he administers each day will not only make a better physician of him, but will prepare him to teach others.

The medical student deserves our deliberate and thoughtful attention. A detailed course in the theory of anesthesia should form part of the instruction of his third year. During the fourth year the theory which has become his may be developed by practical demonstration before large clinics as well as before small groups of clinical clerks. The medical student's appointment to a hospital as a substitute, during the summer preceding his fourth year, and his final establishment as a regular house officer, will then enable him to attack intelligently his actual anesthetic work.

To reiterate briefly the basis upon which anesthesia may be standardized, it may be recalled:

That the duties of the anesthetist are such as can only be properly performed by a fully qualified graduate of medicine.

That the anesthetist is the medical man of the operative team.

That through a misconception of the responsibilities resting upon the anesthetist, the work frequently has been relegated to lay workers.

That these lay workers have been the occasion of preventable deaths from anesthesia, which from the nature of the matter have not been reported as such.

That the institution and the operative team has a moral obligation to the patient, which forbids risking his life by placing it in incompetent hands.

That the standardization of anesthesia requires as a fundamental basis the exclusive employment of medical graduates.

That one of the vicious effects following the use of lay anesthetists is the loss of teachers of this branch of medicine, and its gradual decadence as an art.

That the present interns must meet the emergency by preparing themselves to become teachers, and that the medical students in the third and fourth year classes form the material which shall, through careful theoretical and practical training, provide the expert anesthetists of the future.

DISPENSARY SERVICE BUREAU TO HAVE OFFICE HOURS AT CONVENTION

The Service Bureau on Dispensaries and Community Relations, which, during the past year, has furnished advice and made surveys for a large number of institutions and communities in different parts of the country, will during the convention of the American Hospital Association, at West Baden, Ind., September 12-16, hold regular office hours. At the office hours, members of the Association may consult Michael M. Davis, Jr., director of the Bureau, or one of his associates. The hours and location of the office will be announced in the program of the Convention.

The MODERN HOSPITAL

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HOSPITALS PROFIT BY STATE MEETINGS

THE efficient mechanism offered by state hospital associations for united action on legislative matters affecting hospitals is in itself, in our judgment, sufficient justification for their existence. The brief history of the state associations thus far organized has already demonstrated this. There are, however, other cogent reasons why every state in the Union and every province in Canada should have active state or provincial hospital associations. One of the most important of these is the opportunity offered the hospitals of the states to meet in annual, and in some instances semi-annual, conferences, for the discussion of common problems, particularly those of local or state rather than national scope.

Undoubtedly the national conferences of the American Hospital Association meet an imperative need, and hospital superintendents should make every effort to attend them from year to year; but distance, expense, and other factors will often make this impossible. These conventions, moreover, because of their magnitude, are characterized by a reserve and formality that are less likely to prevail at state conferences where the delegates are apt to know each other more intimately, or at any rate find it easier to get acquainted, so that the state conference offers a better opportunity for the more informal discussion of problems of immediate moment to the hospitals of the state. For these reasons, the larger conferences, valuable as they are, should be considered as additions to, rather than as substitutions for, the smaller meetings.

One state association has adopted the policy, at least for the present, of refraining from any fixed program of formal speeches and has open, informal discussions of topics chosen before the meeting or presented by the delegates.

At last year's annual meeting of the Ohio Hospital Association, the chief of the bureau of hospitals of the state department of health discussed the relation of the State of Ohio to the hospital, in the light of recent legislation. Another speaker discussed the tuberculosis hospitals of the state. The Utah State Hospital Association, at its meeting in June, 1920, discussed the nurses' course to be given by the University of Utah, a subject which was of interest to every hospital in Utah. One paper was devoted to the plan of cooperation between the University and the hospitals of the state. At this same meeting the president of the state association of nurses spoke on the cooperation of her association with the University plan. At the December meeting, the compensation of hospitals for care and treatment under the Utah State Compensation Act was discussed. At its annual meeting last year, the North Carolina State Hospital Association took up the nurses' training school problem, as it affected the State of North Carolina. The members of the Michigan Hospital Association, at their annual conference, had an opportunity to hear what had been done by the state in recruiting pupil nurses.

These, and other topics that might be enumerated, are statewide in character. The meetings of the state hospital association are the appropriate place for their discussion. Have you a state hospital association that makes these meetings possible.

A NUTRITIOUS FOOD PRODUCT ATTACKED

UNTIL milk compound was evolved and placed on the market, great quantities of skimmed milk were returned to the farmer by creameries and cheeseries for disposal as food for livestock or for actual destruction. With the advent of milk compound, however, much of this skimmed milk has been made available for cooking and baking purposes by its evaporation to double strength and the addition of a small per-

centage of cocoanut fat. Such has been its growing popularity that certain interests are now seeking through legislation to stop its manufacture and sale. During the past year, bills which, if enacted into laws, would take milk compounds off the market, have been introduced into the legislatures of five (5) states, namely: Washington, New York, New Jersey, Pennsylvania and Wisconsin. More recently three (3) bills designed to kill the milk compound industry in the United States have been introduced in Congress. The attention of our readers is directed to this matter for the purpose of calling attention to the fallacious and pernicious character of the main contention of the sponsors of these bills—that a compound of skimmed milk and vegetable oil is a menace to the public health. On the contrary, it is a nutritious food product; it bears an honest label; it has passed all the regulatory measures of the federal pure food laws; its ingredients, fresh skimmed milk and refined cocoanut fat, are regarded by authorities as wholesome, nutritious foods; it is not advertised as a substitute for milk or in competition with milk for beverage or direct food purposes and its label clearly states that it is not to be used for the feeding of infants. It is intended for cooking and baking, and as such furnishes an economical, thoroughly healthful cooking accessory.

The manufacture and marketing of milk compound which will give the hospital, and in turn its patients and working staff, the valuable food qualities of skimmed milk in a usable, inexpensive form is to be encouraged, and any legislation looking to its elimination should be voted down.

SEND YOUR SUPERINTENDENT TO WEST BADEN

TO CLASS the coming Annual Conference of the American Hospital Association with the annual conventions of many other organizations—conventions, the outstanding characteristic of which is avowedly recreational and social, and to which the delegates go professedly and primarily to have a good time—is to fall into glaring error. To be sure, the West Baden Conference will have its social and recreational features (it would be an unbalanced and uninviting gathering that did not have both), but the primary purpose of the forthcoming meeting, as of all meetings of the Association, is, and of necessity must be, an educational and professional one. It is in the nature of an annual institute to which hospital superintendents and other executives and trustees come to learn about the latest developments in the field and the most expeditious and modern way of carrying on their several tasks, to discuss knotty problems with their confreres, to see well thought out demonstrations of the work of special departments of the hospital, to consult with thoroughly informed experts in special lines of work, such as dispensaries, social service departments, venereal disease treatment and the like, and to transact vital business affecting the welfare and growth of our hospitals.

Not the least educational in its character will be the exposition of hospital equipment and supplies, in the preparation of which this year an especial effort is being made to make it thoroughly instructive and of practical service to the members of the Association.

No hospital superintendent can afford to miss this series of meetings, and as the knowledge and inspiration gained is taken back and used to improve the work of the individual hospital represented, it is clearly the obligation of the board of trustees of our various hospitals to see that at least the superintendent attends this convention, and to vote sufficient funds to cover the expenses of their representative.

Many superintendents, realizing the benefits of these conventions to themselves and the hospitals they serve, have paid their expenses out of their own pockets. This is not fair to the superintendents. To permit it is not good business practice for the hospitals. Many superintendents of small hospitals, moreover, cannot afford to pay their own expenses to these annual conventions, particularly if they are held at some distance. Yet the superintendents need the help which the American Hospital Association conventions are designed to give. Since benefit redounds to the individual hospitals, boards of trustees can properly regard the expenses of their representatives at the convention as a legitimate charge against the hospital funds, for which full value will be received. Their various communities and the corporate members of their organizations will sustain them in this action.

HOSPITALS IN STATE PRISONS

THE most fertile field for hospital development today is the state and federal prison. With few exceptions, these institutions are almost devoid of what can be truthfully called hospital facilities for their sick and injured.

A man is received in the average state prison after confinement, perhaps, in a filthy jail, and after strain due to trial, and is at once assigned to a cell and a place in which to work.

In choosing his work for him, the officials lay much stress upon what he has done outside. If he has done nothing there, he is sent wherever a man may be needed. The examination of the

man to determine his physical and mental condition is perfunctory; in many cases it is not made at all.

The life of the prisoner is without the attention of medical, dental, or psychological specialists. If surgery is needed, there are only primitive facilities at hand. Sometimes the prisoner is removed under guard to a city hospital for amputation or other operation which is too serious for the prison staff to attempt.

The hospital in the state prison sometimes is a building, sometimes a ward, sometimes a series of cells. The orderlies and attendants are prisoners. The diet kitchen, if it may be called such, is in charge of prisoners. Women nurses are considered out of the question. Male nurses are no more than attendants. The physician, whether part time or full time, is a political appointee, with no incentive to work except the compensation which he earns as quickly and with as little effort as possible. The dentist more often than not is a part time mechanic who takes his pay from the state, and whatever graft he can extract from the prisoner, who is used to such things and pays it without murmur.

A state or federal prison needs a complete hospital in a building by itself, equipped for surgery, dentistry, eye, ear, nose and throat and the ordinary laboratory routine work. The staff should consist of a competent physician of modern training and education, with sufficient medical assistance so that it will be possible to have someone on duty all the time.

The prisoner, on admission, should be carefully examined in every respect, psychologically, psychotically, neurologically; his eyes, ears, nose, and throat should be gone over. Surgical treatment, if necessary, should be applied.

In other words, the man should be put into as perfect physical condition as possible.

His work should be picked for him after a study by the psychologist and other specialists. The effort should be to fit the man for the years he is to spend within the walls, and also to prepare him for the time when he shall again take up his life outside. To do this without hospital facilities, psychological examination and advice, intelligent treatment of his physical, mental, and nervous being, is impossible.

There is the added consideration that the prison of today must make provision for the psychoses. Prison insanity or prison psychosis is a distinct type of reaction found only within the walls. It requires special equipment, including the right kind of building construction. Again, there is tuberculosis, a common disease in prisons. Very little accommodation has ever been made for the segregation of the incipient or of the mildly chronic case. When the disease becomes virulent some sort of segregation is attempted.

In the average state prison little attention is given to public or individual health, yet it is a community in which there is the very greatest need for health work and education.

BOOKS AND PATIENCE

HAVE you ever seen a sick man with a wan, helpless expression on his face, and an uplifted look in his eye, and have you then rushed to his bedside with a book of Horace's Odes or Plato's Republic, and, opening the well thumbed book to your favorite passage, have you read aloud for half an hour in a thrilling voice, and have you looked up to find him—fast asleep? This, figuratively speaking, is the experience of many book idealists when they attempt to elevate the literary taste of the sick, and therefore defenseless, in hospitals. Such is the experience described by Miss Gifford and Dr. Schwab in their article on "Book Therapy in the Barnes Hospital," (p. 134).

They found that illness does not change one's literary taste, at least if it does, the change is for the worse, not for the better. The mind, not being in a very active state during illness, desires something light and easily digested. Detective stories are in great demand, and novels of the type known as "best sellers." It was found, to the horror of the librarians, that the request for "something deep" was best fulfilled by a very sentimental love story.

Therefore, idealists, have patience, do not throw away your ideals, keep them in the back of your minds as something to work toward gradually, but in the meantime face bravely the truth that at present the real function of the hospital library is to help the patients to pass the weary hours. And this, of course, is not a result to be belittled. Anything which helps one to forget suffering or ennui helps to bring happiness, and happiness makes for better health of the body and of the mind.

OHIO ORGANIZES CATHOLIC CONFERENCE

At the convention of the Catholic Hospital Association held in St. Paul, Minn., June 21-25, 1921, the Sisters of Ohio, who numbered about fifty, formed, in the presence of the Rev. J. P. Mahan, S.J., Chicago, Ill., a state conference, adopting the constitution and by-laws which are being used by four other states. The officers elected by the Ohio State Conference Division of the Catholic Hospital Association are as follows: President, Sister M. Gervase, Mercy Hospital, Hamilton, O.; first vice-president, Sister Rose Alexius, Good Samaritan Hospital, Cincinnati, O.; second vice-president, Sister Marcelline, Charity Hospital, Cleveland, O.; third vice-president, Sister Simon, St. Vincent's Hospital, Toledo, O.; secretary and treasurer, Sister Ursula, St. John's Hospital, Cleveland, O. These officers make up the executive board.

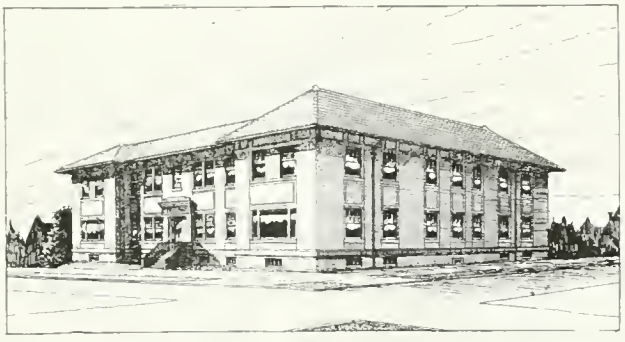
A BUILDING DESIGNED TO MEET THE REQUIREMENTS OF GROUP PRACTICE

By V. N. LEONARD, M.D., The Academy of Clinical Medicine, Duluth, Minn.

THE rapidly growing tendency among physicians to combine their efforts along cooperative lines for the purpose of group practice is creating a demand for special office facilities which were hardly required by the individual practitioner, regardless of the character or extent of his work. The organized group with its corps of assistants, technicians, stenographers, and clerks, as well as its more extensive laboratory and administrative requirements, demands both adequate space and special arrangement for the efficient conduct of its affairs which are difficult or impossible to find in the usual office building. The result has been that a number of groups have seen the advisability of constructing a building which will afford not only sufficient floor space but suitable size and arrangement of the various rooms according to the purposes for which each is intended.

Much depends upon the arrangement of the departmental suites in order that the patient may have easy ingress and egress from all workrooms, but even more, perhaps, upon a suitable arrangement of the various departments with respect to each other, and direct accessibility of each department to the reception rooms, lavatories, rest rooms, and laboratory departments. Special plumbing, lighting, heating, and ventilation must all come in for their share of consideration as well, to obtain ideal conditions. The difficulty of finding a suite of offices or a building which lends itself suitably to the purpose, even after extensive alteration, becomes apparent when these details are considered. Location is likewise a matter of considerable importance, as close proximity to a hospital means much in the efficient division of work between the hospital and the clinic on the part of the staff.

The recently completed building of the Academy of Clinical Medicine of Duluth, Minn., herein described, has been erected by a group of Duluth physicians with the purpose of embodying the various special requirements of each department, and general requirements of group work under one roof. The building, a two story structure of brown tapestry brick with a full basement, is located within a block of St. Luke's Hospital. The foundation is of cement and has been constructed to carry two additional stories. The roof is of red tile. The main section of the building, facing east on Tenth Avenue, has a frontage of seventy-eight feet, while two wings extend westward from either end for a distance of sixty-eight feet, thus forming a court.



The Academy of Clinical Medicine of Duluth.

There are twenty rooms on each of the main floors, arranged about three sides of a large reception room. The first floor plan includes the general office, filing room, office of the business manager, three rooms devoted to gynecology and obstetrics, four rooms for pediatrics, and five rooms for internal medicine. The clinical laboratory, the library and staff room, a rest room for women, and a toilet and wash room for men are also situated on the first floor. On the second floor the general arrangement is the same, all rooms being arranged about three sides of the large central reception room. Two rooms are devoted to ophthalmology, three to otolaryngology, two each to dermatology and urology, three to general surgery, and four to oral surgery. The operating and sterilizing rooms, a dressing room for the staff, the x-ray department, and metabolism laboratory are also located on this floor. The basement contains, in addition to the heating and fuel storage section, a garage for six cars, a pharmacy, an experimental laboratory, animal room, laundry, a recreation room for employees, a steel vault, and several storage rooms.

Special Features

The examining rooms are small, and all but three open on the corridors surrounding the reception rooms. A feature of their construction is the wall cabinet occupying the partition between each pair of examining rooms. These cabinets have been designed in each case to meet the special requirements of the department concerned. All drawers and cupboards in them are accessible from either room, so that one equipment may answer for two rooms. Each cabinet contains an illuminating box for reading x-ray plates, gas and electricity outlets, and a variable number of special features such as compressed air and vacuum outlets, galvanic plates, rheostats, water and instrument sterilizers, irrigating tanks, soiled linen and waste receptacles, etc. When drawers and cupboards are closed everything is out of sight, and protected from dust and injury. Furthermore, by placing practically all the small equipment in the wall, the floor is left clear, and a small examining room, which would otherwise be uncomfortably crowded, becomes very convenient and practical.

Each room contains a porcelain basin with hot and cold water, operated by foot control. The dental and nose and throat departments are equipped with constantly flushing cuspidors which drain directly into the waste pipes. The drainage from the tables in the genito-urinary department is also conducted through the floor directly into the waste pipes.

A set of high pressure steam sterilizers is located off the operating room. Each department is supplied with removable drums which, after packing and sterilization, are placed on a steel stand and operated by foot control.

The building is heated by steam. All radiators have been hung clear of the floor. The floors are covered throughout with a heavy cork linoleum. Denzar lights have been installed in all examining rooms.

The x-ray transformer has been placed across the hall from the x-ray room, in a sound proof closet which silences

it very effectively. Terminals have been run into the cystoscopic room adjoining, so that pyelograms may be taken without moving the patient. The high tension switches are in the attic and are operated by lines through the ceiling.

An automatic flash signal system operated from the telephone switchboard, and flashing in every room and corridor, has been found of great convenience. Patients are called to the examining rooms by means of a small electric light box on the attendant's desk in the reception room, which illuminates the room number from which the signal comes.

Instead of curtains, special inside screens of very fine mesh copper cloth have been fitted to all windows. These screens simplify the ventilating problem as well as being cleaner and more economical than curtains.

BLOOMINGDALE HOSPITAL CELEBRATES CENTENNIAL

By GEORGE W. HENRY, M.D., Bloomingdale Hospital, White Plains, N. Y.

ON MAY 26, 1921, at White Plains, N. Y., occurred the centennial celebration of the Bloomingdale Hospital, which is one of the hospitals maintained by the Society of the New York Hospital, and devoted to the care of incipient and acute cases of nervous and mental disorders. Since its opening, over thirteen thousand patients have been admitted, and of these approximately nine thousand have been discharged improved or restored to health. Formerly, practically all of the admissions were by commitment, whereas at present over eighty per cent of the admissions are voluntary. Corresponding with this, there has been a change in the policy of the hospital so that at present its resources are devoted principally to those cases in which improvement or recovery of health may be expected. To this end, the medical and nursing service has been elaborated so that special study and treatment is given to each individual case.

The program of the celebration exercises consisted of addresses delivered both in the morning and afternoon, luncheon served on the lawn at noon, after which a tableau-pageant was presented on the recreation grounds. Over two hundred physicians, as well as a large number of laymen, were present, and among these were many of the leading psychiatrists, neurologists, and psychologists of this country.

In the morning, an historical review of the hospital was made by Edward W. Sheldon, Esquire, president of the Board of Governors of The Society of the New York Hospital. He referred briefly to the granting of a charter to the Society of the New York Hospital by King George III of England on the thirteenth of June, 1771; the first admissions to the New York Hospital of mental cases shortly after the Revolutionary War; the establishment of a separate building accommodating seventy-five mental cases in 1807; the establishment of Bloomingdale Hospital as a separate institution in 1821 on a site then in the country, but at present occupied in part by Columbia University of New York City; and finally, the transfer to the present buildings in White Plains, N. Y., made in 1894, on account of the rapid development of New York City, and the desirability of a rural community both for its own virtues and the opportunity for still further development in the hospital itself.

General view of Bloomingdale Hospital, White Plains, N. Y.

After this brief historical review, Dr. Adolf Meyer, professor of psychiatry, Johns Hopkins Medical School, presented "The Contributions of Psychiatry to the Understanding of Life Problems." In general he referred to the valuable contributions made to society, concerning the development and relationships of psychological forces and mechanisms governing human behavior, by the study of their abnormal manifestations as seen in the mentally disordered.

Dr. Lewellys F. Barker, professor of medicine, Johns Hopkins Medical School, made the third address of the morning on "The Importance of Psychiatry in General Medical Practice." He emphasized the great practical need of psychiatrical information on the part of general practitioners of medicine, better cooperation and understanding between general practitioners and psychiatrists, and called attention to the rapid development of interest in psychiatry on the part of the general public. He also mentioned the fact that the best schools of medicine in this country are now requiring courses in psychiatry extending over two and three years.

In the early part of the afternoon, the development of the understanding and care of patients suffering from mental disorders obtained a graphic representation in the form of a tableau-pageant under the direction of Mrs. Adelyn Wesley. Some of the scenes presented were the "Granting of the Charter at the Court of King George III," a courtyard scene in Salpetriere in 1792, in which Pinel enters, saddened and indignant at the sight of so much unnecessary suffering, and instantly orders the chains to be struck off; and a scene presenting the occupational recreational activities of the modern hospital.

This was followed by an address by Dr. Richard G. Rows, director of the Neuro-Psychiatric Hospital, London, England, on "The Biological Significance of Mental Illness." Dr. Rows emphasized the importance of the emotional associations with physical experiences occurring early in life, the way in which they modified the development of an individual, their appearance in more or less disguised form in psychoses, and also referred to the probable close relationship between many psychotic mani-

festations and abnormal functioning of the ductless glands and sympathetic nervous system.

Dr. Pierre Janet, professor, College of France, Paris, then discussed "The Relation of the Neuroses to the Psychoses," saying, in general, that neuroses represent

Sport scene from the pageant held at Bloomingdale Hospital, May 26, 1921.

a degree of abnormal behavior intermediate between the peculiarities of the normal individual and the grossly abnormal behavior seen in psychoses. Significant excerpts from his discussion are as follows: ". . . this distinction between the neurotic sufferer and the mental sufferer was mostly arbitrary and depended more than was believed upon the patient's social position and fortune. . . . It seems to me fair to preserve the distinction between neuroses and psychoses considered as different degrees of psychological decadence. . . . Neuroses are, therefore, the intermedium between the errors and faults which appeared to us almost normal, and alienation which seemed exceptional and distinct from us."

The program was concluded by "Remarks on the Medical Development of Bloomingdale Hospital," by Dr. William L. Russell, medical superintendent of Bloomingdale Hospital. Dr. Russell reviewed briefly the crude methods of treatment in the latter part of the eighteenth century,

Occupational therapy scene, from the pageant held at Bloomingdale Hospital, May 26, 1921.

the introduction of moral treatment in 1817 by laymen as something distinct from medical treatment, the adoption of moral treatment by the physician in charge of the hospital as part of the medical treatment in about 1830, and finally the appointment of a physician in 1877 who

should not only direct the medical treatment but should also be the chief executive of the hospital. Dr. Russell continued by making the prediction that very soon hospitals for the mentally disordered will become mental hygiene centers through which the general public may benefit by the knowledge obtained from the study of mental disorders, and preventive medicine may be practiced on a large scale.

The addresses, an account of the celebration, and various historical documents relating to the hospital will be issued in a special volume which will be published by the governors of the hospital.

BOOK THERAPY IN THE BARNES HOSPITAL, ST. LOUIS

By ELEANOR R. GIFFORD, Volunteer Worker, Barnes Hospital Library, St. Louis, Mo., and SIDNEY I. SCHWAB, M.D., Professor of Clinical Neurology, Washington University Medical School, and Neurologist to Barnes Hospital, St. Louis, Mo.

In an article by Elizabeth Green, librarian, and Sidney I. Schwab, neurologist of Barnes Hospital, some of the medical uses of a hospital library were described, and the library work was placed among the extra-medical activities of the hospital. The present article deals with the clinical aspect of some of these ideas at the hand of one who tried to carry out in the hospital what was left of the theories of book therapy when the patients were through with it.

It is evident from experience, that illness does not elevate ones taste in the matter of literature. Rather, it often works the other way. Instead of asking for the finer types of literature the patients demand sentimental love stories, and tales of wild adventure. Thus amusement seems to be at present, all that can reasonably be hoped for from the use of books in the hospital.

IN A previous paper,[1] the librarian of the Barnes Hospital, and one of the authors of this article, described some of the medical uses of the hospital library and the various methods by which patients might be put into contact with books during their stay in the hospital. They had in mind at that time a kind of book therapy; that is, a selection of books based upon the medical need of a patient, a sort of literary prescription. The various things that reading might do for a patient were described, and a place for a library and its various activities was found in the routine of a hospital in what might be called its extra medical field. This present paper deals with what is in reality the clinical aspect of some of these ideas at the hands of one who tried to carry out in the wards of the hospital what was left of the theories of book therapy after the patients were through with it. It is evident from the experience of the authors that the hospital use of books cannot be directed or analyzed as are other types of treatment, because the patient not only is the object of treatment, but is the final judge in regard to the question of receiving treatment at all, and the kind of treatment he is to receive. If a patient for whom book therapy is prescribed does not wish to accept his medicine, there is, of course, no way by which he can be compelled to do so. It is a good thing to know this because it will save us a lot of trouble in the future and keep us from pressing too vigorously either the therapeutic use of books or their rigid selection.

Standards the Same In and Out of Hospitals

In or out of a hospital, good taste in the matter of books is rare, and a patient, no less than his perfectly well brother, has only a mild interest in the finer or more subtle aspects of literature. A book is good if it is interesting, a story is good if it is exciting, and if it succeeds in carrying the reader outside and away from the stress of the present. Style, good taste, and truth are to the average reader a secondary matter. An experience with sickness does not change personal qualities or alter an individual's reaction to literature. It is, therefore, easy to see why the patient in the wards of a hospital should ask of a book just what he would ask of it when in ordinary health. The spiritual quality so often seen on the face of the sick does not, unfortunately, reflect an alteration in the quality of appreciation which he may or may not have for finer things. Or, perhaps, the spiritual quality of which so much is made in romances is only a very temporary thing, and does not cut deeply enough to profoundly offset a dull perception of literary beauty. Often, indeed, experience seems to show that sickness tends to decrease whatever amount of such appreciation formerly existed. With a few exceptions, books are read to pass away the time, to lighten the dreary hours of convalescence, or to help through the expectant period of preoperative tedium. If books can do this, and without doubt they do, then their place in a hospital has been found, and their usefulness has been amply demonstrated. It is well, therefore, that the limits of book therapy should be clearly seen, and that what is accomplished by offering an opportunity to patients to read is about what is done when the same individual reads a book away from the hospital, in the normal environment in which he lives.

In the paper alluded to, it was pointed out that a hospital library should contain only good books, and that an attempt should be made to exclude from the patient's selection books that either have no literary merit or offend in good taste or decency. This, of course, provides a very broad line between what is good and what is bad. It is worth while to attempt to decide what a good book is from a hospital point of view. Obviously the best hundred books or the five foot shelf would not go, either in the wards or in the private pavilion of a hospital. A good hospital book might be said to be one that contains nothing in it absolutely bad from the point of ethics or morals, that appeals to the conventional taste of respectable people, that does not attempt to analyze character too solemnly, or investigate personality by any of the tenuous methods that are in vogue at the present time. Patients as a rule are not interested in a study of motives, or the underlying causes of things, but desire entertainment furnished by the more obvious and superficial. Novels, therefore, that fulfill this description are

1. "The Therapeutic Use of a Hospital Library," The Hospital Social Service Quarterly, August, 1919.

those found in the pages of our most popular weeklies, and those that most often reach the upper stratum of the best sellers. Above all, a good hospital book must tell a story vividly, interestingly, and simply. The play of the plot is the play of the people in it as men and women, not as complicated individuals stressed and torn by the intricate clash of conflicts. For this the average patient has little liking. Queer people in or out of books have no appeal for the average American, and to the average person anything different is apt to be the abnormal. For this reason the shelves of a hospital library should be filled with books that contain nothing that would violently assail preconceived conventional standards of the average American citizen, who becomes the average patient in a hospital. Exotic drugs as well as exotic books must be reserved for unusual and rare cases, so there should be a small portion of one shelf reserved for books of this type to be supplied to patients of this class.

Educational Development an Ideal

The educational and mental development through books, of a patient in the hospital is perhaps an ideal to contemplate, but scarcely one that can be put into practical application. It must not be forgotten that a patient who is convalescent is a patient whose mind is not fit for the reception of any new ideas, or perhaps may be too receptive for their proper digestion. He is either too willing or too unwilling to accept that which is foreign to him in the light of his former experience, and it would perhaps be too great a risk to take advantage of a too susceptible state of mind. Therefore, on the whole it is necessary to limit the selection of books to those which conform to the most conventional standards. Here again it might be well to leave for the exceptional individual the selection of books that might conform more to his particular personal culture or experience with literature. An attempt might in some instances be made, however, to persuade a patient to accept an introduction to a type of literature that in his normal period he would not have welcomed. It has been found that an amusing book is a good hospital book, therefore the humorists of all ages should be well represented in a hospital library. Books of travel are popular books, perhaps because to most of the patients travel is only possible through books. The bulk of the library, however, should be entertaining fiction.

In analyzing the character of books demanded by your reading patients the element of type of hospital must be considered. The problem presented by a general hospital is very different, for instance, from a tuberculosis sanatorium, where a patient usually stays a long time. With the rapid "turn over" of a general hospital, such as the Barnes, where the average number of hospital days per patient is fifteen, you pretty well eliminate the possibility of doing more than catering to an already established taste in reading matter. This means that only in exceptional cases you have a chance of continued personal contact with a patient, and it is only through such association that a taste for better literature can be developed.

Unusual requests are worthy of investigation, for often they indicate a need not before recognized. A recent request for an arithmetic from the metabolic ward was followed with the discovery that a patient wanted to "brush up" on decimals, in order to be able to carry out the diet that he must learn to regulate properly, before leaving the hospital to resume life at home again. Needless to say an arithmetic is now added to our collection.

For six years or more at the Barnes Hospital, St. Louis, there has been a definite system for supplying patients in the wards with reading matter for their interest and amusement. After all, do we seek any effect, other than to while away some of the sad and tedious hours, in the same way that the bit of crocheting and bead work, the basket weaving, and the making of toys help in these happy days of occupational therapy? To many, the reading of a whole book or even of a whole story is a serious and fatiguing undertaking. Others "read a little sometimes," and a few are ready for two, three, or four books every time the little book truck appears, which is twice a week. Some have the reading habit already, and some will never acquire it anywhere, but in between these two groups is a small percentage which takes on the reading habit, temporarily at least. This is the group of patients who are in the hospital for a long period, and among them one finds not infrequently the man who "never cared about books nohow." Suspicious, resentful, suffering, he is sure you are trying to put something over on him. "What church do you come from?" "Not any," says the worker, "the books belong to the hospital." "How much do you charge?" "Nothing, you are quite welcome to them." At this point, with the "patter" developed by the library social service worker, "We just bring them around, because the nurses are pretty busy, you know, and we can give you time to look at several books, if you'd like to try one." "I can tell from the outside of any book if it's any good," is one astonishing assertion. "Do you see anything here you'd like to try?" and the volunteer turns the truck to present the row of books to the crippled man. "I might look at that red one there."

Perhaps he takes it, perhaps not, but the next week he dislikes us a little less, and in the long months that follow he will often take many volumes, and that he reads a good part is assured, for he talks about some of the adventurous heroes whom he learns to like or tolerate a little. Perhaps in the next bed the man is beginning to weave a basket, and is fascinated by the new occupation. "Don't need a book this time," he says proudly. We admire the basket and pass on. It may be that the next week finds the hands weary and the book or magazine is very welcome. And so we make our rounds, approving the bits of handicraft, admiring the babies, mailing letters, doing any trifling service possible, and distributing our wares where wanted, but never urging them upon any one.

Right Book to Right Person

In a small way we attempt to fit the right book to the right person, possibly not too successfully with the very limited library at hand. We learn, however, that the demand for "something deep" is usually satisfied by a highly impossible and intensely sentimental love story, that the frail little old lady who wants "nothing but blood and thunder" will be quite content with Zane Gray or Jack London, and that the Bible goes to the negro ward along with the highest colored romance. A request for "A Life of Napoleon or some kind of history" may have to be met with "A Life of Washington," or a "History of England," but the substitute is often satisfactory. When one finds a lad of seventeen with all too little schooling, struggling vainly with Conrad's "Rescue" which "someone had just left around," it is easy to replace the book with another which will take the reader through more than the three pages where Conrad left him gasping. Sometimes a patient is gently led along the road from "Alger" and the numerous "Motor Boys," to a little different literature, but better the trivial page, it seems to me, so long as the book is not vicious, than nothing at all.

The effect of the library work, if it may be so dignified,

upon the volunteer is well known and it is most wholesome. As for the patients, reading surely helps pass the time and bring happiness, and certainly when one grows happier he is better in body and mind. To most of us Harold Bell Wright can never be inspiring, nor can Miss Porter's over-cheerful "Pollyanna" tide us over a hard experience, but these two most popular authors (at Barnes Hospital) are deserving of much gratitude. To forget one's pain for even a little, and live briefly in another world, to taste a bit of the adventure and romance so far away from the hospital ward, is to gain something. At all events I know that the reading world both in and outside the hospital is a happier one than the world that sits or lies idly looking into space.

REST, WORK, PLAY, EXERCISE FOR CARDIACS

In a report by Dr. Frederic Brush, medical director of the Burke Foundation, White Plains, N. Y., many interesting facts are given concerning the results obtained with 2,500 cases of valvular heart disease treated from April 15, 1915, to July 1, 1920.

The admission standard is the question "Has the patient the reserve to be rehabilitable to full or handicapped wage earning or living power in a few weeks of rest-work-play-exercise treatment in the country?" On his admission the patient is given an examination to fix his status as to the kind and amount of exercise possible, the position of his room and the amount of required rest. There are facilities for every kind of outdoor and indoor game. Baseball, so dear to the heart of the American male, is no longer forbidden, on the other hand, it is encouraged, though in a mild form. Dancing, croquet, tennis, and soccer are only a few of the diversions that are provided. There are several "short-golf" courses, and this game has on the whole been found the most satisfactory. There is a constant effort to get away from the old régime of "don'ts" and "can'ts" which have become so much a part of the patient's life, and educate him to a normal way of living.

The average day of a typically progressive male patient in the third week gives a good idea of the routine: "Rise at 6:30; sit outdoors or walk, breakfast at 7:30; make bed and tidy room; morning papers, smoke (no restrictions upon this), brag and argue world problems, wash and repair own clothing, go to store, library, or barber shop; play games outdoors and in; obligatory medicine ball, etc.; take supervised walks on the grades; glass of milk at 10:00; prescribed occupation, 10:20 to 11:30; rest, dinner at 12:30; "rest hour," 1:00 to 2:00, flat on bed with no talk; play in or watch outdoor sports or tournaments, walk to the village a mile away or do a few hours of work on farm or buildings (for a half wage); supper at 5:00, rest, walk, or games, read or write letters, dance; bed, and lights out at 9:00."

It is shown by the figures which have been collected that it is important to get the cases in youth or middle age. It is often questioned whether from four to eight weeks of such treatment can produce any lasting benefits for this class of patients. The affirmative answer is given measureably by the results and is confirmed by the physicians, welfare workers, and others who have seen the product of it during the last five years. Its practicability depends upon cooperative organization, extending from hospital entrance through convalescence on to life work and follow-up, and this term of exercise, etc., should only be regarded as one link in the chain of reconstructive effort.

SHOULD TRAINING SCHOOLS BE AFFILIATED WITH COLLEGES?

The American Journal of Nursing is inviting discussion on the possibility of solving the training school problem, or some of the difficulties of that problem, by affiliating training schools with colleges or universities. Elizabeth Selden, San Francisco, Cal., in the March issue, opens the discussion with an article giving a plan for such an affiliation. Miss Selden feels that the main deficiencies in the present education of pupil nurses are: lack of instructors, poorly prepared instructors, lack of knowledge of the needs of the student, inadequate equipment, lack of human clinical material, the giving of classes in the evening or at times when the student is too tired to benefit by them. The students entering the schools are found to be poorly prepared in many necessary subjects, and usually, if they are only of high school age, too immature to deal with the problems which they will have to meet.

Miss Selden believes that a panacea for these evils may be found in the establishment of central schools of nursing, which will be connected with colleges or universities, and from which the students may serve an internship in hospitals. In other words, Miss Selden advocates the adoption of a system very much like that of medical education. The applicant would enter the school and reside at the home provided by the school of nursing, a department of the college. She would remain here as a student for either one or more years, as required by the college, visiting affiliated hospitals, where she would study the concrete examples of the theory learned in the class room. The practical nursing methods would be taught at the college in specially equipped laboratories, with practical application at an affiliated hospital. The hours for such visits would be arranged to suit the hospital. The hospitals would then requisition the school for a certain number of pupil nurses, and the students would be placed by the school in the various hospitals as pupil nurses. The central school would still maintain some supervision over them. Miss Selden feels that such a plan would make for a more uniform training, and also a better and more thorough training. She feels that it would raise the standards of the nursing profession, and be more economical of equipment and of human energy.

INDUSTRIAL PHYSICIANS EMPHASIZE PREVENTIVE MEDICINE

The annual conference of the American Association of Industrial Physicians and Surgeons held in Boston was a marked success. The program consisted of five sessions full of interesting discussions and papers. The prevailing note was the development of preventive medicine in industry, and the promotion of industrial health knowledge among employers and managers. The necessity of proving the value of expenditures for health in industry was felt.

Some of the leaders of business in New England who spoke before the meeting emphasized the permanence of the programs for health in industry. Their approval was complete, and this means much in times of retrenchment such as the present.

The following officers were elected: president, Dr. C. E. Ford, General Chemical Company, New York City; first vice-president, Dr. C. F. N. Schram, Fairbanks, Morse and Company, Beloit, Wis.; second vice-president, Dr. L. A. Shoudy, Carnegie Steel Company, Bethlehem, Penn.; secretary-treasurer, Dr. William A. Sawyer, Eastman Kodak Company, Rochester, N. Y.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
132 E. 45th Street, New York City

RELATION OF NURSING SCHOOLS TO HOSPITALS

BY SARA E. PARSONS, R.N., JEFFERSON CITY, MO.

DURING this period when practically everyone is interested in the problem of recruiting student nurses for our hospitals, there are certain factors that ought to be conscientiously considered in connection with this activity.

We are learning that even the best of our schools fail to measure up to the standards that educators consider essential. It would seem that we have overlooked the fact that schools imply not only students, but well prepared teachers, classrooms, and equipment, and time for instruction and preparation for classroom work.

It should be recognized that the present system of training nurses is wrong from the foundation, although much that is good has resulted in spite of manifest defects. In the first place hospitals with which most of our recognized schools are connected have no moral right to sacrifice, in the name of charity, their obligation to the student nurse to the economic necessities of the institutions. There are of course times of emergency when students must rise with the rest of the hospital personnel to unusual duties until the emergency passes. But as a matter of routine the practice of using students to do the work that properly belongs to maids, porters, orderlies, or graduate nurses, is not justified. If the institution is not in a position to finance the nursing department as a school, it has not the right to undertake that educational function. There is of necessity expense entailed with any educational program.

Bedside experience, while the most important factor in the education of nurses, is but part of the necessary experience, and it should be remembered that it must be carefully planned to meet the needs of the student nurse as a student. Unless a hospital is prepared to give a well balanced course in at least the four major branches of medicine, viz.: medical, surgical, pediatric, and obstetrical experience as well as theory, affiliations should be made to meet this standard.

Candidates Now Younger than Formerly

There are other adjustments in our present system that must be made before our nursing schools can possibly bear favorable analysis. It must be remembered that our candidates are now much younger than they used to be when nursing as a profession was young. Conditions that were then bad were not so reprehensible when the majority of the student nurses were of mature years. Then both physique and judgment were well developed, in comparison with the strength and judgment of girls just graduating from high schools. Now that we are accepting these younger candidates we are morally responsible to them and to the patients we care for that there should be proper supervision, instruction, and selection of their work in the hospital. Some of the practices that obtain in many institutions all over the country are entirely unsuitable for student nurses. There is no excuse in any hospital for requiring students to take the entire care of male patients. We all know that male patients themselves dislike exceedingly having young women attend to their most intimate needs when they are helpless but in full possession of their senses. Orderlies when taught are perfectly well qualified to attend to certain demands of male patients, and student nurses would not be deprived of anything essential to their education.

The practice of twenty-four hour duty in institutions where the special nurse sleeps in the room with the patient is another one of the reprehensible practices that is seldom justified by the necessity of the patient. The facts if honestly stated are these:

The patient if sick enough to need twenty-four hour attention ought to have two nurses, as it is impossible for one nurse to do justice to her patient if on call twenty-four hours for any length of time. If the patient is not sick enough to require two nurses he can perfectly well get along with such attention as the floor nurse is able to give at night. There are very few hospitals that have reasonable accommodations for the nurses even where this practice is carried on habitually. The appearance in the corridors of nurses *en negligée* is demoralizing and undoubtedly accounts partially for the fact that thoughtful parents do not wish their daughters to take up the nursing profession, when their experience of nurses has been in institutions where such practices occur.

Practices Often Abused

The custom of having student nurses act as special nurses for private patients or serve as floor nurses in private wards chiefly to earn or save money for the hospital should be very carefully regulated if allowed at all. The practice as it used to exist before the student shortage, was much abused. Students were habitually deprived of class study, and recreation time.

Living conditions for students that could not possibly bear the inspection of a health officer ought to preclude the maintenance of a nursing school.

We shall be working at cross purposes which have already led to great confusion and almost to disaster until we realize that a trained nurse should be a person of at least fair education to start with, a woman of good home

training and with real love for her work, prepared by two or three years of teaching and practice under the direction of properly qualified teachers, in a school or hospital or both, where good moral and professional standards obtain; also where is given a well balanced course of theory supplemented with intensive practical nursing experience in at least the four major branches of medicine.

We find ourselves at the place now where the good and intelligent woman who is also well trained has made her work of such value that she is in great demand all over the world, in many branches of nursing and health activities. On the other hand about 80 per cent of parents object to the profession for their daughters, although there is not a more splendid preparation for life in all its phases than nurses' training when the education of the nurse is what it should be.

Nurses Best Judges of Necessary Education

Unfortunately neither the medical profession nor the general public yet fully appreciates the fact that trained nurses are themselves the best judges of what kind of preparation they need for the demands that are made upon them, and it would seem from the diversity of opinion among medical men that but few of them have ever given any serious thought to nursing education from the point of view of the patient or the nurse. The surgeon is satisfied with the nurse who can do good surgical work; the up-to-date medical man is satisfied with the nurse who understands scientific dietaries and can give intelligent care to his patients. Likewise with the obstetrician and the pediatrician. It hasn't occurred to them apparently that few women wish to be confined to so narrow a channel of usefulness as any one of these specialties. The modern young woman wishes to feel herself equipped to undertake intelligently the practice of general nursing, and preparation for general nursing is the only education that prepares her for usefulness as a public health nurse, Red Cross nurse, or any of the many executive and teaching positions that are open to trained nurses. If our medical friends stop to consider nursing schools seriously from the point of view of the prospective candidate they would not advocate hospitals indiscriminately as suitable places for training schools; neither would they expect any considerable number of fairly intelligent people to be satisfied with the kind of experience offered in most hospitals. The medical men who say they prefer the practical nurse whom they train themselves should understand that, while that may be satisfactory to themselves, it is no reason why they should expect that method to be satisfactory to the community, and it is no reason why they should oppose any plan by which a comprehensive and adequate preparation may be secured for those who desire it.

There are many pitiful instances at the present time of graduate nurses who are obliged to say that their schools have gone out of existence or have become so disorganized that they are ashamed to tell from what place they graduated. It is an obvious fact that many very good schools at the present time rely entirely on the interest and intelligence of the present heads. If the heads of these schools were to leave it would be difficult for even a well informed training school committee or board of trustees to find a suitable substitute, leaders are so scarce. But unfortunately the boards and committees that are sufficiently well informed to actually realize what is involved in the maintenance of a nursing school are so few that the chances are that a young and inexperienced graduate might very probably be promoted to a position requiring unusual qualifications.

All who are interested in nursing education should ponder upon the fact that there are very few states where there is any control or inspection of nursing schools and that in the practice of nursing there are few states where there is any control of practical or graduate nurses, or protection for those who are really trained and registered. There are many who suppose that registration is obligatory, but such is not the case in most states.

In the schools throughout the country that offer the least to their students there are a large number of students who drop out during the course and take up nursing as graduates. A superintendent said recently that she had counted up sixteen or seventeen who had dropped out of her school within four years and were practicing as graduates of the school to the detriment of their patients, and the reputation of the school from which they profess to have been graduated. It is seldom that these students who drop out before the course is completed have had practice in the care of children or maternity cases. The fact that the work in most hospitals is about three-fourths surgery, and about three-fourths of the patients are "specialled" by graduates through the critical part of their illness probably accounts for the monotony and loss of interest during the second and third years.

To those who are postponing a reorganization of their nursing schools, under the delusion that presently large numbers of young women who are being laid off from office work will apply to nursing schools under the old system, I would say that during the past few years there has been increasing publicity among high school and college girls as to what constitutes a good nursing education. Besides the guidance of vocational directors there will be in the future the information obtainable from the Rockefeller committee now investigating nursing schools, and the information disseminated by public health nurses. No nurse who has been a victim of a poor school will recommend another to follow her example.

Finally, I would call attention to the fact that any nursing school that desires to attract an intelligent class of candidates should be so organized that financially and educationally the student's interests will be protected, and a change of personnel will not hazard her education nor endanger the value of her diploma either in the immediate or distant future. This leads us to the conclusion that the schools of the not distant future must be definitely connected with recognized colleges or universities, or, if with hospitals, the school department must be so directed and financed that it will be able to compete in the excellence of its instruction with university schools. In the future applicants will seek institutions that have a solid foundation.

INSTITUTE OFFERS INTERESTING COURSES

The Michigan State League of Nursing Education held an institute in Ann Arbor, Mich., from June 6 to June 17. The institute was attended by 176 representatives coming from seven states. A $5.00 fee was charged to all graduate nurses who attended. Lectures, demonstrations, round tables, and clinics were held. The lectures covered a great variety of subjects, but most of them were concerned with hospital problems, and training school methods of teaching student nurses. Following is a list of some of the lectures given:

Principles of Teaching, James B. Edmondson, A.M., professor of education and inspector of high schools, University of Michigan, Ann Arbor.

Psychology of Teaching, Walter B. Pillsbury, Ph.D., professor of psychology and director of psychological laboratory, University of Michigan, Ann Arbor.

The Training of Public Health Nurses, Mrs. Barbara H. Bartlett, B.S., R.N., professor of public health nursing, University of Michigan, Ann Arbor.

SOCIAL SERVICE IN NURSES' TRAINING

By CLARA A. GRIFFIN, Training School for Nurses, Massachusetts General Hospital, Boston, Mass.

AN IDEAL laboratory for the study of the functions of public health service is afforded by the outpatient department of a general hospital. The student nurse is detailed here during some part of her training, and this time should be made to yield a direct contribution to her preparation. The special point of vantage from which most light is thrown upon the various activities is the social service department, and a growing number of hospitals are giving short courses in this department to their pupils.

What can a nurse get from this intensive experience that she does not get from her work in the wards? In the first place, she has the advantage of viewing her old job from a new angle of vision, of seeing herself as others see her, as her patients see her. Divested of her uniform and the authority it lends her, she stands or falls upon the merits of her own personality, and has the unique opportunity, while yet within the hospital service, of stepping out from the ranks of doctors and nurses, and watching their pursuits with the eyes of an outsider.

Gets Knowledge of Background

To carry her message of health to the community she needs to supplement her knowledge of disease as she finds it in the hospital, by study of its social aspects as a destructive factor in human lives, a force stalking hand in hand with crime, poverty, and ignorance. As a social worker she discovers the elements of environment which react upon the individual, predisposing him to disease, and sees how the surroundings of neighborhood and home, or the hazards and strains of his work contribute to his disability. The collection of this material aids in the rounding out of a course of treatment based not only on medical facts but also on the social situation.

If she goes still further and traces the reaction of disease upon the family of the patient, she brings to light the complications of the medical problem as a whole. This includes the adjustment of the economic situation, solving the question of support for the family, disposal of the children, or meeting hospital expenses for the patient or other members of the family. Another phase opens up when it is necessary to arrange for the after-care of the patient, either in his own home or in some convalescent institution, to supplement treatment by obtaining apparatus, braces, or supplies. Social work here should aim to clear away all the obstacles that block the way of successful medical treatment.

The opportunities for health education are unlimited in all social work, and the student nurse has here a chance to try out her powers of teaching under actual conditions. Her work begins with the interpretation of the doctor's diagnosis to the patient, and should continue until he understands the purpose of the prescribed treatment, and realizes fully the large part which his own efforts and mental attitude play in bringing about recovery. It is not complete until the whole family have learned not only the essentials of caring for the patient, but a number of simple lessons in right living as well. The first steps of preventive work, chief among our future concerns, are nowhere better taken than in the family of the ex-patient, whose health relations with the community are now formed, and whose interest is ready to be enlisted in nutrition classes, baby hygiene clinics, child welfare movements, and the like.

A new bond of alliance between nurse and patient grows up as the result of her increased knowledge of his background and handicaps. As a social worker she learns how to develop this understanding by means of case work, that process of collecting and relating the facts of social evidence, which aids so greatly in the formation of habits of open mindedness, suspended judgment, and fair dealing. She is led to realize more than ever the signal influence of her personality upon her patients, and her responsibility to exert it in furthering their best interests. This she can most effectively do by studying social methods of making contacts as they apply to winning the confidence of the patient, overcoming his prejudices, or the right use of persuasion and suggestion.

Cooperation Most Valuable Lesson

The lesson of cooperation is perhaps the most valuable single teaching of social service work for the student nurse. Whatever her future work, its success depends upon her ability to enlist the cooperation of the patient and his family. The mental attitude of the patient, important as it is in stimulating or retarding recovery, may be deeply affected by the nurse, and often the family is hardly less susceptible. As she practices the best ways of securing team-work in the family and in the community, she comes to see that measures of precaution or of hygiene are least effective when simply imposed by health officer or nurse, and most so when actively shared by the family or neighborhood group, with some true comprehension of their responsibility.

Cooperation as developed by social service also includes the interplay of all those agencies, public and private, which can bring their special branch of helpfulness to bear upon the solution of the patient's problem and the rearrangement of the factors that make up his life. For the student this means practice in working with a great diversity of organizations, in the art of securing the maximum of results with the minimum of friction. She learns to adopt other people's methods, meet their office hours, comply with their regulations or restrictions, and understand their general purpose. She should know how to select from each association the type of service that it can most appropriately and most effectively render. Some insight into these resources is of great practical value to every nurse, and only by taking part in its operation can she gain an idea of the complexities of the system, and of how to avail herself of what it has to offer with the least amount of lost motion and duplication of effort.

While it is evident that social service training contributes directly toward the preparation of a nurse for public health work, it is also evident that it can be of benefit to all nurses. Such a course, which cultivates unbiased vision, tolerance, and the habit of handling human problems constructively, is an experience of especial value to students who wish to take institutional positions. The very type of girl who might be least likely to elect the course because it did not bear directly on her future work, might be the individual most in need of the indirect results of its training, for this schooling in the humanities lays a foundation for any administrative position. Moreover, when this young woman has graduated, and takes her place, let us say, in the admitting office, she may find a close connection between the knowledge of budget making

and rate fixing required in this department, and the first hand study of home conditions made possible by social service.

The criticism of Sir Arthur Stanley, head of the English Red Cross, that the present nurses' training is too narrow and does not sufficiently qualify for work on the broad lines now being carried forward, voices the opinion of a number of educators. It can be met by developing the beginnings of a more general training which already lie within the present system, and making the resulting courses available to a larger number of students. That the nurses themselves feel the need of a wider range of experience is evidenced by the returns from a questionnaire sent out to the graduates of thirteen representative training schools to which five hundred and fifty nurses replied. In answer to the question, "What subject or experience might have been added with positive advantage to your professional life?" they replied with so much emphasis that the report states that "The loudest demand is for social and public health subjects, social service, visiting nursing, and preventive medicine."

"SPACE AND TIME AGAIN!"

An experienced British coroner seems to have given a slight jump on hearing a hospital nurse say incidentally in his court that she had washed a patient about 3:20 a. m. So little may the stoutest professional lookers at seamy sides of life know about the sorrows of whole masses of mankind. To the patient in large hospitals, civil or military, the severity of the hour at which he may get his morning wash has long been about the largest of the very few flies disfiguring what is, upon the whole, a most handsome pot of gift ointment. Old soldiers compare, with breaks in their voices, the hours at which they have been washed at Delhi and Aldershot, at Havre, Versailles, and Rouen. Almost incredible stories are told of ablutions begun before midnight in very full wards in remote stations: "the dark places of the earth are full of cruelty." Strangely, these woes have not yet found their sacred bard, though Verlaine has written a whole book on "My Hospitals"; Henley, lying in his Edinburgh public hospital, did once begin a famous lyric with the words:

Out of the night that covers me,
Black as the pit from pole to pole,

but then, instead of going on to say how he issued from night into the presence of a tin basin, pale soap, and a flannelette towel, he diverges into reminiscences of Swinburne and talk about his own indomitable soul. Only the eloquent moderation of the American horse thief who, when told that he would be hanged at dawn, said that it seemed a poor way of beginning the day, can do justice to the controlled bitterness of the patient summoned from Elysium at four, five, or six on a winter's morning to be made clean for the long, blank day.

The nurse is always kind, but so, no doubt, was the man who drew Priam's curtain in the dead of night and told him Troy had fallen; so was the worthy in "Measure for Measure" who called Barnardine before sunrise, announcing "Your friend, sir; the hangman. You must be so good, sir, to rise and be put to death"; but no amount or quality of velvet on the glove can wholly soften that steely hand to our poor flesh and blood. The victims, conferring afterwards with bated breath among themselves, like the huddled patients just emerged from a sheepwash, have generally understood that their bane was a system which kept a night staff on until about seven or eight, and ordained that it must not go off duty till everyone washable in a ward had been washed. The shallowest student of mankind will see how this system, operating upon a nurse of provident temperament, distrustful of her own speed, may end in his being washed at 3:20 a. m. But there is no real grumbling. "Under the bludgeon strokes of fate"—which, again, Henley in hospital applied to less urgent sorrows—the sufferers own, with bowed heads, that the system has its roots deep in the conditions of man's tenure of the earth. To get them all washed at seven o'clock there might have to be as many nurses as patients. The fundamental trouble is that incorrigible lapse of time which takes place while you are doing a thing, that irrepressible intervention of space which robs every bed in a ward, however well organized, of the direct and immediate enjoyment of the ward sink outside. The two malign powers that generate theatre queues and necessitate postmen and taxis—these, and not any mere blackness of the administrative heart, are responsible for the shock to the coroner.—*Manchester Guardian*, April 8, 1921.

TEACHERS COLLEGE OFFERS FIVE YEAR NURSING COURSE

The advantages to the nurses of having a college degree as well as a degree in nursing are unquestioned. Teachers College, therefore, is offering a five year course which aims to combine the advantages of college work and nurses' training. The first two years the student lives at the college and receives an introduction to the cultural subjects which are considered fundamental in a college training, as English, history, languages, etc. At this time she enjoys as many of the social and intellectual opportunities of the college as possible. The third and fourth years are spent in a hospital, either the Presbyterian or St. Luke's, where the fundamental professional training is given. A fairly large proportion of this time is spent in practical nursing service.

The fifth year is largely elective, the student selecting some one of the many branches of nursing and devoting herself to it.

Students must be graduates of accredited high schools and must meet the requirements of Teachers College for matriculation. Before being admitted to the hospital in the third year, students must meet the requirements of the hospital training school which they wish to enter.

For application blanks and information, apply to the Director of the Department of Nursing and Health, Miss M. A. Nutting. For information concerning the Presbyterian Hospital, apply to Miss Anna Maxwell, superintendent of nurses, and concerning St. Luke's, to Mrs. Carrie Bath.

NURSES ELECT OFFICERS

At the recent meeting of the Canadian National Association of Trained Nurses, the following officers were elected: president, Miss E. M. Dickson, Toronto; first vice-president, Miss J. Brown, Saskatchewan; second vice-president, Miss E. Johns, Vancouver; treasurer, Miss J. Wilson, Saskatchewan; secretary, Miss F. MacMillan, Edmonton; archivist, Miss F. Potts, Toronto; editor, Miss H. Randall.

CANADIAN ASSOCIATION MEETS

The following officers were elected at the fourteenth annual convention of the Canadian Association of Nursing Education, held at Quebec, in June: president, Miss G. M. Fairley, Hamilton; first vice-president, Miss M. F. Hersey, Montreal; second vice-president, Miss M. F. Gray, Regina; third vice-president, Miss M. Catton, Ottawa; secretary, Miss M. McNeil, Winnipeg; treasurer, Miss F. Potts, Toronto.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU GRAVES,
5618 Winthrop Avenue, Chicago, Ill.

DIETETICS IN THE COTTAGE HOSPITAL SANTA BARBARA

BY FLORENCE H. SMITH, B.S., AND W. D. SANSUM, M.D., SANTA BARBARA, CAL.

MANY human ailments are due to errors in diet. Modern investigations lend increasing weight to this assertion. It is important, therefore, that hospitals have efficient dietary departments, both to insure maximum advantages to patients and to serve as an educational center for physicians, dietitians, nurses, patients, and others interested. A brief summary of some of the more fundamental dietary principles, pointing out some of the grossest violations, will illustrate the need for a more general knowledge of dietetics.

Must Have Sufficient Calories

The diet should contain sufficient calories. It requires a very definite and constant amount of food to satisfy the requirements of the body at bed rest. This amount, known as the basal metabolic rate, may now be determined by simple methods. Above this amount the requirements of the body increase chiefly with the activity of the individual. Women, especially, are prone to eat too little and to fail to increase their diet in proportion to their activity. The severer limitations of diet often produce chronic invalidism, which is frequently associated with severe headaches. The food requirements for growing, active children often exceed those of their parents. Babies are more frequently overfed than underfed. Obesity is usually the result of eating too much while leading a sedentary type of life.

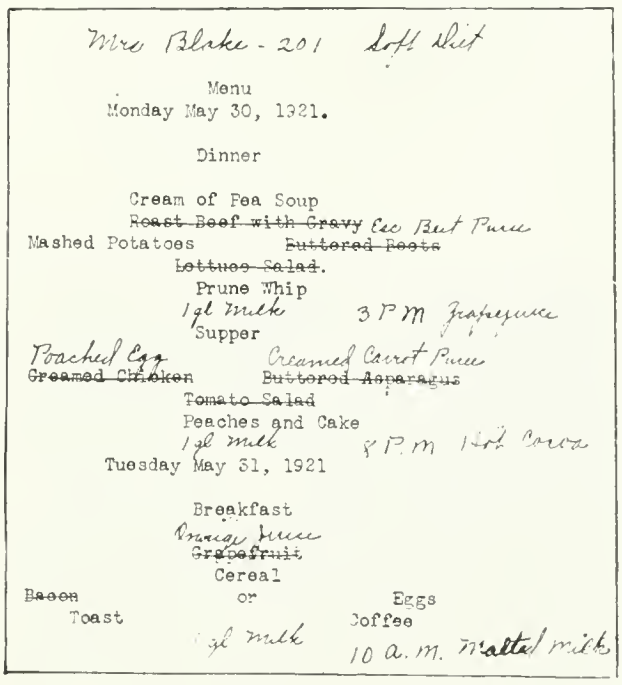
Sufficient Protein for Nitrogen Balance

There should be sufficient protein in the diet to maintain the proper nitrogen balance. Here again the diet of women is frequently deficient. Children need more protein in their diet in proportion to their weight than adults, due both to their activities and the needs for growth. Men frequently consume more protein than is necessary, which may be an etiological factor in the production of arterial and kidney disease. The edemas seen in Europe during the war were due largely to protein starvation following the requisition of the meat supply for the fighting armies.

There should be a proper balance between the various food elements. This error is best illustrated in diabetes, where the patient loses the greater part of his ability to use carbohydrate. Under these conditions fat is not properly oxidized and forms the toxic acetone bodies. This type of dangerous acidosis is not limited to diabetes. It is frequently seen in children, during pregnancy, in post-operative cases, and in the treatment of obesity where the loss of weight is too rapid. It is due to an improper balance between the carbohydrate on the one hand and the protein and fat on the other. Whenever this acidosis occurs it can usually be eliminated by an increase in the carbohydrate, a decrease in fat, or both.

Should Be Sufficient Bulk in the Diet

There should be sufficient bulk in the diet. It is maintained by many physicians that more than one-half of the ailments which cause patients to seek the aid of a physician may be directly or indirectly traced to constipation or its complications. Perhaps 99 per cent of this disease is either due to the lack of sufficient bulk in the diet or to the injudicious use of cathartics. This is a national ailment and is perhaps more peculiar to this country than any other. It is due largely to the fact that



Mrs Blake - 201 Soft Diet

Menu
Monday May 30, 1921.

Dinner

Cream of Pea Soup
~~Roast Beef with Gravy~~ Ec Beet Puree
Mashed Potatoes ~~Buttered Beets~~
~~Lettuce Salad~~.
Prune Whip
1gl Milk 3 PM Grapejuice
Supper
Poached Egg Creamed Carrot Puree
~~Creamed Chicken~~ ~~Buttered Asparagus~~
~~Tomato Salad~~
Peaches and Cake
1gl milk 8 PM Hot Cocoa
Tuesday May 31, 1921

Breakfast
Orange Juice
~~Grapefruit~~
Cereal
~~Bacon~~ or Eggs
Toast Coffee
1gl milk 10 a.m. Malted milk

Fig. 1.—A Cottage Hospital menu.

THE DIET AS ORDERED FOR THE NEXT 24 HRS.

Where it is feasible this change in diet should be made at the next meal following this order. Such articles as clear broth, tea, coffee, pepper, salt, vinegar, agar jelly, bran agar muffins and saccharine which contain no sugar formers may be used in the amounts desired by the patient.

Name John Brown Date June 14 Time Breakfast

Amount	Kind of Food	Distribution to Meals			Food value in grams of		
		B	D	S		Prot.	Fat
	Purée cooked vegetables						
400	3% vegetables	133	133	133			
200	6% vegetables		100	100			
3	Eggs	2		1			
3	Lista Muffins	1	1	1			
	Milk						
10	Oatmeal	10					
25	Butter	5	10	10			
10	Bacon	10					
75	Lean Meat		50	25			
100	36% Cream	33	33	33			
100	10% Fruits	33	33	33			
	White bread						

Signed H. D. S.

Fig. 2.—A diabetic diet order.

people live mostly upon refined, residueless foods rather than natural foods in their more bulky state.

There should be a sufficient amount of the so-called vitamines. Typical extremes of the deficiency diseases, such as xerophthalmia, beriberi, scurvy, and pellagra, are rarely seen in this country, and it has not been definitely decided that all of these diseases are due to lack of vitamines alone. Many cases of varying degrees of malnutrition due to the lack of these important elements are seen, however, especially in children in the large cities where pure milk and fresh vegetables are unavailable in sufficient quantities.

There should be a sufficient amount of mineral foods. Neither the seeds of plants, tubers, like the potato, nor the meat animals contain a sufficient amount of mineral foods to support life properly. It is now believed that rickets is due to a deficiency in both calcium and phosphorus. The anemias are frequently due to the lack of iron. The leafy vegetables and milk contain these elements in large available amounts.

Administration of the Dietetic Department

The organization of the dietetic department is under the direction of the chief dietitian. She is responsible to the medical directors of the hospital and clinic for the serving of all diets ordered, and for the instruction of patients requiring dietetic treatment. The dietitian's attention is given to the general problems of the dietary department. She consults with the purchasing agent on food qualities, cost, and deliveries. Storage conditions of food come under her supervision, also the conservation of supplies and the regulation of food waste. Kitchen improvements and equipment are recommended by this department. The dietitian is responsible to the superintendent of the hospital for the personnel of the department and the organization of its workers.

Dietary Department of the Cottage Hospital

The dietary department in the main hospital is under the direction of an assistant dietitian, whose duty it is to provide the chief dietitian with a report from the department each day. Food for the patients is prepared in the main hospital kitchen. The food and service in the dining rooms of the staff, nurses, and employees are under the supervision of the dietitian, the food being prepared in the main kitchen. A special diet kitchen and serving room are a part of the main unit. All patients' trays for the main hospital are served here. This work is organized in a way calculated to prevent errors in filling diet orders; to serve the patient in the most acceptable manner; and to conserve time for doctors, nurses, and dietitians. A list of house diets has been accepted by the staff. These lists are posted where all responsible for ordering and serving the diets may refer to them.

The normal diet is used as a basis for all diets served. This menu is planned by the dietitian. The stencil is cut, and mimeograph copies made for all patients. These copies are sent to the floors, where the nurse in charge marks a copy for each patient, with his name, room number, and the diet order as written by the doctor. The dietitian then takes these sheets and if necessary consults with the nurse in charge and the doctor ordering the diet, before filling out the menu as it will be served for the next twenty-four hours. (Figure 1.)

Dietitian Visits the Patient

The dietitian visits the patient, discussing the diet with him, teaching the therapeutic value of the foods served, and learning his likes and dislikes. Patients are better nourished under these conditions and much food waste prevented. Special diets are served with a high degree of accuracy following this method. The number of orders for the kitchen and serving rooms are taken from the menu slips. No copying is necessary and all departments have definite orders from which to work. This menu slip is kept in the serving room and placed on the tray each time it is set, to act as a guide in serving and checking the diet before it is sent to the patient.

Dietary Department of the Potter Clinic

The chief dietitian supervises the work in this wing of the hospital, with an assistant dietitian in charge of the metabolic kitchen. Here pupil nurses receive training in the preparation and serving of diets. In this department many patients, physicians, dietitians, and graduate nurses are taught the preparation and calculation of special diets.

Name John Brown
Date June 14 Time Breakfast

	B	D	S
3 x Cooked veg.			
3% vegetables	133	133	133
6% vegetables		100	100
Eggs	2		1
Lista Muffins	1	1	1
Milk			
Oatmeal	10		
Butter	5	10	10
Bacon	10		
Lean Meat		50	25
36% Cream	33	33	33
10% Fruit	33	33	33
White bread			
Beverages	C	C-B	T
Agar jelly		1	1
Note			

Fig. 3.—A tray slip.

The quantitative diets of the hospital are prepared and served from the metabolic diet kitchen. These diets in-

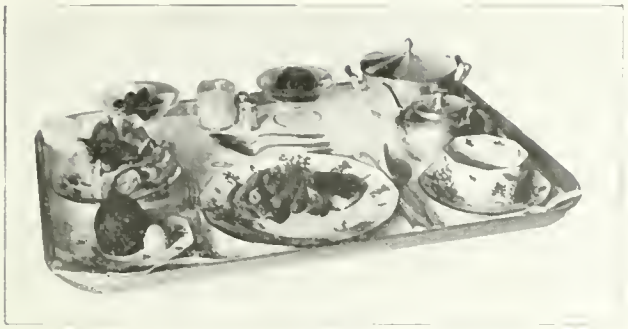


Fig. 1.—A diabetic dinner.

clude chiefly those ordered for diabetes, nephritis, high blood pressure, undernutrition, obesity, and gout. The diabetic diets require the most attention, since they vary with each case, and from day to day, during the process of treatment, depending upon the laboratory reports.

Three copies of the diabetic diet are made whenever a new patient enters the hospital or whenever any change is made in the diet. These copies are made in triplicate on mimeographed forms. (Figure 2.) One copy is reserved as a permanent record for the hospital chart; a second copy is given to the dietitian, and the third copy is given to the patient. The duplicate copies prevent errors that might otherwise occur in copying orders, and also save time. It will be noted that on these diet orders, in addition to the kind and amount of foods ordered, the distribution by meals is indicated. There are also spaces provided for the estimation of the food values. These spaces are used by the dietitian in preparing the food summary for the chart, and by the patient, under the direction of the dietitian, in estimating the food value of his diet. A copy of the diet in the hands of the patient serves as a double check, for he is instructed to report any error at once to the nurse in charge. To avoid confusion in the serving of food, a small tray slip is used. These forms (Figure 3) are mimeographed, and save much time in serving the diets. The slips are intended for the use of the nurse and dietitian serving and checking the trays, and are copied only when the diet order is changed.

School of Hospital Dietetics

In consultation with the instructress of nurses, the chief dietitian plans practical and theoretical training in dietetics for the student nurse.

This dietitian also has charge of the training school for dietitians which the hospital provides. This course of training has been made possible by the hearty cooperation of the superintendent of the hospital and the medical directors of the hospital and clinic. In planning this work for the student dietitian, we have kept in mind the fact that she is a woman of highly specialized training coming to us for practical work in hospital dietetics.

Every effort has been made to give the student only such work as will be of educational value to her. It is evident that the institution offers unusual advantages to its students because of the combination of clinical and institutional work available. An opportunity will be given, under careful supervision, for the student to specialize on the subject elected by her. Each student usually spends six months in residence to complete the course. The institution furnishes board, room, and laundry to the student dietitian.

Course of Study for Student Dietitians, Cottage Hospital, Santa Barbara

The object of this course of study for student dietitians is to present the organized work which is available at the Cottage Hospital and the Potter Metabolic Clinic of Santa Barbara, to college and university students desiring institutional training.

This institution proposes as far as possible to accept only those students who have received the degree of Bachelor of Science, or are juniors in a course leading to the degree of Bachelor of Science.

Practical Work

I. Organization.
   1. General plan of the hospital.
   2. Organization of the metabolic kitchen.
   3. Organization of the general kitchen.

II. Food Service.
   1. Planning and supervision of the preparation of food for patients on special diets in the Cottage Hospital.
   2. Requisitioning of food supplies.
   3. Care and storage of food supplies.
   4. Regulation of food waste.
   5. Care of Equipment.
   6. Employment and organization of workers.
   7. Menu making for the Cottage Hospital.
   8. Supervision of the preparation and distribution of food for the Cottage Hospital.
   9. Supervision of serving rooms and dining rooms in the Cottage Hospital.
   10. Instruction of pupil nurses in practical work.
   11. Planning, preparing, and weighing of food for patients requiring quantitative diets.
   12. Instruction of patients in food preparation and diet calculation.
   13. Preparation of infant feedings.

III. Field Work.
   1. Cottage Hospital Dispensary.
   2. Open Air School.
   3. Public school.

IV. Basal Metabolic Measurements.

V. Dietary Studies and Cost Accounting.

VI. Computing and Recording the Value of Food Intake for patients receiving quantitative diets.

VII. One hospital problem (subject elective).

Theoretical Work

I. Ethics.
   1. Viewpoint of institution.
   2. Viewpoint of patient.
   3. Viewpoint of doctor.
   4. Viewpoint of nurse.

II. General Principles of Hospital Dietetics.
   1. Needs of patient: home environment, religion, race, social position, physical condition.

III. Lectures on Nutrition.
   1. Dietetics of infancy and childhood.
   2. Dietetics of pregnancy.
   3. Dietetics of pre- and post-operative cases.
   4. Dietetics of special diseases:
      a. Metabolic.
      b. Cardio-vascular-renal.
      c. Gastro-enteric.

Fig. 3. The metabolic diet kitchen.

d. Acute infectious diseases.
IV. Research privileges.
1. Potter Metabolic Food Laboratory:
Problems assigned by the director of the clinic, as individual problems in diabetes, nephritis, etc.
2. Potter Metabolic Laboratory:
a. Metabolism in diabetes.
b. Metabolism in nephritis.
c. Individual problems as assigned.
3. Potter Metabolic Library:
1. Magazines—assignments made by instructor;
a. Journal of the American Medical Association.
b. Journal of Biological Chemistry.
c. American Journal of Physiology.
d. California State Journal of Medicine, etc.
2. Books—as assigned for special problems.
4. Dietetic Seminar—Chairman,
Twelve lectures.
V. Observation Work.
1. Hospitals of city.
2. Retail markets.
3. Bakeries.
4. Hotel kitchens.
5. Tea rooms.
VI. Preparation of Course for Teaching Pupil Nurses Dietetics.
VII. Study of Service Problems and Factors Influencing the Efficiency of Employees.
VIII. Contracts.
IX. Equipment.
1. Manufacture, value, placement, care, etc.
2. Problem—Outline equipment for dietary department of 200-bed hospital.

COME TO THE AMERICAN DIETETIC ASSOCIATION MEETING

The fourth annual meeting of the American Dietetic Association will be held October 24, 25, and 26 at the Hotel LaSalle, Chicago, Ill. Miss Emma Gunther of Teachers' College, experienced and successful maker of programs, is chairman of the program committee. With her are working the section chairmen. Each of the four sections will have charge of one morning or afternoon session, a round table discussion, and part of an evening program.

The administrative section, in charge of Miss Mary Lindsley, manager of the Grace Dodge Hotel, Washington, D. C., will present the results of the study which administrative dietitians have been asked to make, in regard to equipment, household supplies, food, wages, and morale of employees. This information will be grouped and presented by the dietitians in charge of the Illinois, Michigan, Eastern, and Southern divisions. It will represent the best experience of trained dietitians in institutions in all sections of the country. The speakers will include experts on institutional management and architecture.

The education section, in charge of Dr. Ruth Wheeler, professor of nutrition in the Medical School of the University of Iowa, will present the work done by the committees of this section dealing with the hospital training of the student dietitian, graduate work for the dietitian, and the curriculum for teaching dietetics to nurses in training schools. The curriculum for nurses is being prepared at the request of the Association for Nursing Education and will be discussed by prominent representatives of that organization and of the American Dietetic Association.

Miss Rena Eckman, University of Michigan Hospital, chairman of the section on dietotherapy has arranged for the presentation in condensed form, of the work done in dietotherapy during the last three years. This will include recommendations as to the extent to which it is practicable to carry out these developments in hospitals and in other fields. Such nutrition experts as Dr. Amy Daniels and Dr. Woodyatt are to speak on this program.

Round tables, in all sections, are especially arranged, and it is hoped that they will be free and helpful discussions by all persons interested in the problems specific to each section.

There are to be other things beside work at the convention. This is an excellent opportunity for dietitians to get together, to know each other, to develop a real fellowship. The Chicago Dietetic Association plans a tea for Monday afternoon, and the Monday evening meeting will be a dinner meeting. Because of the large number of activities interesting to dietitians, in Chicago, the local branch has arranged the following plans for Thursday morning following the convention.

Hospital trip—Visit to the hospitals of interest in the city.

Commercial trip—Visit to hotels, restaurants, industrial cafeterias, and the like.

Infant welfare trip—Trip through the infant welfare stations.

Trip to the University of Chicago commons.

Luncheon at the Chicago Beach Hotel.

Guides are to be provided, and a definite itinerary for each trip is to be arranged. Surely these will prove too tempting to be declined.

Plan to make this trip to the convention a part of your vacation! To dietitians in every field the meeting will be filled with interesting information, stimulating associations, inspiration for a new year, and a deeper understanding of true professional spirit.

NEWS ITEMS

Miss Elizabeth Powers is supervising a department of dietetics at the Mercy Hospital, Council Bluffs, Iowa. Readjustments in the kitchens and new equipment have helped to develop very pleasing working conditions and Miss Powers makes the proud boast that she has the finest diet kitchen in the state. Miss Powers was formerly at Harper Hospital, Detroit, Mich.

Miss Louise Pollock has recently gone to Minnequa Hospital, Pueblo, Colo. Dr. Corwin's vision and plans for the future in the dietetic department make us want to keep in touch with what is being done in this hospital.

Miss Roberta T. Carver is giving up her work at Cincinnati General Hospital in order to do graduate work in dietetics. She will be at Teacher's College for the summer.

Miss Bettman, who was in the Public Health Service, Ellis Island, N. Y., succeeds Miss Isabel Stewart as dietitian at Montefiore Home, New York.

Miss Hazel Chambers, head dietitian at Michael Reese Hospital, sends us this pleasing report of changes in personnel in her department. Students who have recently finished training with her have accepted positions as follows: Lois Hill is with Dr. Amy Daniels at the University Hospital, Iowa City, Iowa; Hazel Winders is dietitian at St. John's Hospital, Springfield, Ill.; Helen Raymond is assistant dietitian in the United States Public Health Service Hospital, Boise, Idaho; Ruth Chambers, formerly dietitian at Post-Graduate Hospital, Chicago, has succeeded Mrs. Sackman as assistant dietitian at Michael Reese.

Miss Mildred Keet is dietitian at the New Britain General Hospital, New Britain, Conn. Miss Keet took student dietitian training at Lakeside Hospital, Cleveland.

Other changes have been made by dietitians as follows: Miss Ruth Cornman has been transferred from United

States Public Health Service Hospital No. 30 in Chicago, to No. 52 in Boise, Idaho; Miss Theresa Clow from the department of dietetics in the public institutions of Illinois to a position with the Y. W. C. A. in Chicago; Miss Alice Ferguson of Missouri Baptist Sanatorium will rest all summer at her home in Galesburg, Ill.; Miss Lita F. Wheeler from the City Hospital, Springfield, Ohio, to Decatur and Macon County Hospital, Decatur, Ill.; Miss Adelaide Weber from the Grant Hospital in Columbus to chief dietitian at the Harper Hospital, Detroit, Mich.; Mrs. Mabel Tanner, from the Mary Fletcher Hospital, Burlington, Vt., to State Hospital for Mental Diseases, Howard, R. I.; Miss Mayme Lewis has resigned her position at the Foote Hospital, Jackson, Mich., and is at her home in Columbus, Ohio.

Miss Blanche Eames, who had student dietitian training at the Peter Bent Brigham Hospital, has accepted a position at the Protestant Deaconess Hospital in Indianapolis, Ind.

Miss Inistore Sims, a graduate of the home economics department of the University of Illinois has accepted a position as chief dietitian at the Vaughn Memorial Hospital in Selma, Ala. Miss Sims is a southern girl, so knows the food habits of the Alabama people, and is familiar with problems of the servants in that section of the country. This, coupled with her unselfish and likeable personality, makes us most optimistic as to the future of the dietary department at Vaughn Memorial.

Miss Margaret Kilburn has accepted a position as head dietitian at the Ithaca City Hospital. Miss Kilburn had nurses' training in Edinburgh, Scotland, and more recently has been associated with the dietary department at Royal Victoria Hospital, Montreal.

Miss Ruby Odell is dietitian at the Corning Hospital, Corning, N. Y. Miss Odell graduated from the home economics department at Cornell in June. Previously she took the student training course at Southampton Hospital, Southampton, L. I., and after finishing the training was given the position of dietitian.

The editor of this department will be in Chicago during the summer months; mail addressed to the office of THE MODERN HOSPITAL will be promptly received. After November 1, her address will be Mount Sinai Hospital, New York.

The Chicago Dietetic Association met at the Hospital Library and Service Bureau Room on Friday evening, May 20. Mr. Butler of the Commissary Department of the Pullman Car Company gave an interesting talk on the service on private and dining cars. Mr. Minor of the Rockwood Products Company gave a short talk on some of the faults women have in buying.

The following report comes from the dietitians of Philadelphia: On Friday evening, May 13, at 7:30 o'clock, thirty-four members and friends gathered to do justice to the good dinner planned by the committee, Miss Alice Hall, Miss Eunice Bowser, and Miss Euphemia Cameron. Each one found beside her plate a favor in the form of a funny little doll made from a lolly-pop, and a card upon which were written jokes and jingles appropriate to the occasion. The table, arranged in the form of a horseshoe, gave us an opportunity to indulge in jollity. Each one was asked during the dinner to tell the funniest thing that had happened in her professional life, or to read the joke upon her card. In this way everyone was heard from and the plan contributed much to the success of the evening. The menu was attractive, I think you will agree when you read the following:

Grapefruit

Boullion in cups Rolls
Creamed chicken in patty-shells French-fried potatoes
Peas

Head lettuce salad Cheese dressing
Strawberry ice cream Fancy cakes

Black coffee

After the dinner, Mrs. Fuller, as retiring chairman, took the opportunity of saying a few words of welcome to the company. She then recalled the occasion of the formation of the club, over four years ago, and took pleasure in bringing to mind the fact that Miss Gilson was the founder of the organization, and of extending to her the tribute of our appreciation. Then the newly-elected chairman, Miss Claribel McCrae of the Philadelphia Hospital, was introduced. Miss McCrae responded in pleasing fashion, laying stress in her remarks upon the necessity of making our club a strong one and extending its usefulness, as well as keeping in close touch with the American Dietetic Association.

Upon the conclusion of Miss McCrae's remarks the company enjoyed singing popular airs and dancing.

At the head of the table, where the new officers sat, were fine bouquets of flowers, one for each of them, as well as one for Miss Gilson. While the dancing was going on, those to whom the bouquets were given shared their flowers with the other members.

Good-nights were said about 10 o'clock, everyone expressing pleasure in having shared in so enjoyable an occasion.

STUDENT DIETITIAN TRAINING AT THE MAYO CLINIC, ROCHESTER, MINN.

The Mayo Clinic at Rochester, Minn., offers a six months graduate course in dietetics. This course is conducted by trained dietitians under the supervision of the members of the clinical staff.

The major part of the practical work is given at the Olmsted Hospital, which is an institution devoted to metabolic diseases and pediatrics. It is equipped with facilities for serving large numbers of patients with prescribed or weighed diets of known composition. The dietitians are in close association with the patients and physicians, and are able to observe the effect of diet on the course of disease.

The course further includes practical training in other hospitals affiliated with the Clinic, and thus provides experience in the preparation of diets of all kinds and practice in planning meals for large institutions.

Training in the principles underlying the subject is provided by means of special lectures and quizzes, and by general lectures on medical subjects. The latter include the Mayo Foundation lectures and the clinical discussions for nurses which are held by various members of the Clinic staff.

Persons interested may address inquiries for further particulars to Miss Mary Foley, chief dietitian, Mayo Clinic, in care Olmsted Hospital, Rochester, Minn.

MISTAKE CORRECTED

The paper on nutrition problems by Miss Anna L. De Planter, published in the department of Dietetics and Institutional Food Service in the July issue, was read at the March monthly meeting of the dietitians' section of the Home Economics Association of Philadelphia, instead of at the third annual meeting of the American Dietetic Association.

He will always be a slave who does not know how to live upon a little.—*Horace.*

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

THE MARKET'S TREND

By CHARLES L. HAYS, Chicago, Ill.

BUSINESS has been saved from the usual midsummer dullness by an exceptionally strong demand for hot weather merchandise of all kinds. A record-breaking spell of high temperature since the latter part of May has almost cleaned out merchants' stocks of light apparel, white goods, and wash fabrics of all kinds, and this profitable turnover is reflected in more confident buying for fall trade. In some lines, however, demand is very slow. These include building supplies, house furnishings, implements and machinery, jewelry, and other articles in this class of luxuries. Wholesale orders are satisfactory, and in those for immediate shipment are ahead of the volume at the corresponding time last year. This habit of buying seems to have become fixed among merchants, and with transportation service prompt, as it is now, is not likely to be changed until prices reach a permanent basis. Textile markets are steady, the margin between consumption and production is narrower and stocks are getting low. These conditions are wholesome and make a good foundation for business revival.

A steady decline of more than two months in the security markets has had a disheartening effect on the financial situation, although money conditions have become slightly easier in the last month, especially in the East. The shrinkage in values has been mostly in the securities of industrial corporations, the earnings of which have been most seriously affected by dull business and the decline in inventories. It has not been severe in standard issues and high class investments; indeed these have benefited in some cases from the more liberal supplies of money and the shaking of confidence in less stable securities. Investment demand, after having been almost at a standstill through June, has shown some improvement since the first of July and the flotation of new security issues has been resumed with satisfactory results. This field of finance is likely to be dominated for the rest of the year by the needs of the railroads, and large amounts of new securities of this class may be expected in the next few months. The condition of the transportation lines has been materially improved since they have regained in a measure control of their operating expenses, a part of the war advance in wages has been rescinded and the government has taken steps to refund some $500,000,000 due the roads for improvements made during the period of Federal operation. These changes make for the financial rehabilitation of the carriers and will make the securities they are about to offer much more attractive to investors. With the government guarantee they should, provided reasonable care in selection is taken, afford excellent opportunities for investment by both institutions and individuals.

Building Activity Slight

Building operations are still in a very low state. Settlement of the labor troubles in Chicago drags, and it is doubtful if it can be completed in time for much of a revival this year. Work on unfinished projects was resumed when the controversy was submitted to arbitration last month, and construction of scores of small dwellings was begun; but large projects are still held up to await the final adjustment, the fixing of a new wage scale and the removal of jurisdictional union disputes. The building already under way has relieved the unemployment situation considerably, and brought about moderate activity in the markets for materials, but is much less in volume than was expected or the housing needs demand. Even in the interior, where labor affairs are a less important factor, little is being done, and the effect of this inactivity is felt in many lines of trade—hardware, house furnishings, lumber, brick, roofing, paint, in fact everything that goes into buildings. There have been no important changes in prices in the last month except for steel. Bars, wire, pipe, nails, boiler tubes, bolts, nuts and other supplies have been reduced $4 to $12 a ton, but the belated revision has not yet stimulated much buying. Mills are operating at 25 to 30 per cent of capacity and orders are few.

Except for the improvement noted in the building trades there has been an increase in idleness, despite the calls for help from the harvest fields. Shoe and textile manufacturing is on a little larger scale, but in other industries signs of revival are lacking. Wages continue to be reduced, and in most cases the downward revision is accepted with little opposition. Living costs are lower, but there is a sharp contrast in this respect between conditions in the large cities and those in the towns and country districts. In the former food prices stay high, but in the latter they are much more nearly in line with the cost of supplies.

Hot weather and drought have caused an advance in the prices of dairy products in the last month. Butter is up five cents a pound and cheese one to two cents. Eggs are five to 7 cents higher and chickens three to five cents. Prospects of an abundant crop this year have depressed grain prices to new low prices. Flour is fifty cents to $1.00 a barrel lower than a month ago, and

cereals in bulk have undergone further revision downward. Sugar, after declining to 5.30 cents a pound wholesale in New York, has had a fractional reaction. Consumption is large, but the high price of fruit has held canning in check and shut off a large demand from that quarter. Financial troubles in Cuba and a large stock of raws to be marketed are factors of weakness in the wholesale trade. Canned goods are firm and higher, principally because of a light pack this year, the reduction in some cases amounting to 50 per cent. Peas, beans, and tomatoes have been most affected by the shortage. Provisions are higher, hams three to four cents and other cured meats two to four cents, while lard is up $1.00 a hundred.

Paint materials have not held the rise of a month ago, the demand from new building being disappointing. Linseed oil is down from eighty cents to seventy-six cents, warehouse delivery. Turpentine also has shown weakness, declining from sixty-one to fifty-seven and a half cents.

Furniture prices are maintained and business is dull. About the only lines in which there are signs of concessions are metal beds and other articles into the construction of which steel enters. Domestics, sheetings, and pillow cases are steady, especially the well known named brands, for which the public demand has been better of late and surplus supplies have been absorbed. Price reductions in staple cottons have been fewer this month in spite of a further decline in the raw material.

Crude rubber sold at ten cents a pound, the lowest price on record, and while there has since been a recovery of about two cents, the market has not hardened materially. There are said to be 75,000 tons of the commodity stored in this country, and as much more in England, so there is not likely to be much improvement in the market unless the revival in the automobile business assumes much larger proportions than now seems imminent. As in the cases of most other lines of manufacture, however, finished goods reflect only faintly the drastic decline in raw materials. Further reductions will depend largely on the course of labor and distribution costs; but the tendency is downward rather than upward.

Drug trade has been quiet and prices are steady pending the framing of the permanent tariff schedule. Refined glycerin has been particularly easy, with demand slow and competition keen. Chemically pure is quoted at fifteen and a half to sixteen cents and lower grades as cheap as twelve cents. Formaldehyd is in fair demand at thirteen and a half to fourteen cents. Quinin demand is limited to small quantities, prices holding at sixty-seven to seventy cents. Menthol is firm at $4.00 on diminished supplies. Alcohol is slightly lower at $4.90 to $5.00. Antipyrin is firm at an advance of $2.25 to $2.50 a pound. Carbolic acid stocks have diminished and prices are firm at ten to fifteen cents. Small quantity purchases are the rule and developments of interest in the last month have been few.

FOOD HANDLING AND PUBLIC HEALTH

NO EXTENSIVE thesis need be written to argue that public health is indissolubly bound up with factors affecting nutrition. Physical development proceeds in well ordered sequence, only if the nutrition is adequate and uninterrupted. Deformities, retardations, and even mental defects may be charged to deficiencies of food supply during critical periods of development.

It is not to be wondered at, therefore, that environmental conditions as affecting the food supply have long commanded the attention of the biologist or that the physiologist has worked out the specific requirements of the human organism at various stages of growth and under the varying conditions of human life.

Health workers have long realized that public health measures are largely ineffectual unless food is adequate to the needs of the organism, hence the social worker was called upon to supplement the research of the laboratory, in accounting for conditions of malnutrition that affect large percentages of the populace, and the economist has evolved the balance between costs and earnings which must be considered essential for the maintenance.

Parallel with this study of the human machine has proceeded the analysis of foods. The early contributions of the chemical laboratory were erudite and uncomprehended by the multitude. The man of the street did not see what bearing the "biochemistry of pathogenic anaërobes" could have upon human welfare. The application of specific studies in food values was scarcely more apparent, and few people could be induced to order their lives on an engineering basis of so many heat units as the equivalent of so much energy. It was here that psychology made a contribution in discerning disease causes in debilitating food habits. Concessions were necessarily made to racial food habits and even to individual food idiosyncrasies, the essential knowledge of the chemical content of certain staple foods making possible substitutions to keep up the nutritional balance.

Enter the Vitamines

It was not long, however, before the interest in food as food was stimulated by the introduction of the "vitamine content phase" of research, which lessened the importance of energy producing food and emphasized the existence of elusive, unanalyzed, unisolated food factors, the absence of which in any dietary results in scurvy, beriberi, or rickets, and accounted for a whole range of deficiency diseases which materially affect personal efficiency and public welfare.

In a remarkably short time esoteric interest in food substance has given way to a rather general realization that scurvy and eye troubles may develop from low fat-soluble, low calcium, poor protein, and unsatisfactory salt combinations; that polyneuritis results from a lack of the water-soluble B which is procurable in yeast, spinach, wheat, soy beans, eggs, milk solids, and cabbage; and that scurvy is caused by a dearth of the water-soluble C which is best derived from fresh fruits and vegetables.

Our knowledge is now ample to guide safely the populace close to the sources of foods; but where questions of preservation and transportation enter into the picture, a wide range of scientific investigations became necessary to determine what vital content is lost by heating, whether a community depending upon cold storage or dessicated products is necessarily subject to vitamine starvation, and how deterioration—whatever the cause—affects food products.

Bacterial Ferments

The relation of bacteria to the food of man is another comprehensive field of research, much of which has

centered about milk products—milk, cream, butter, ice cream, and other articles of universal consumption. All milk, today, becomes more or less contaminated at the time of its production. Hence all milk and consequently all butter become contaminated with decomposition and ferment products. In view of the voluminous literature on this subject it would seem that nothing new could be pointed out in connection with the influence of possible incubating temperatures on the qualities of milk, cream, and butter. Nevertheless, Dr. J. M. W. Kitchen, in a recent contribution on "Temperature Control as Related to Improvement in Milk, Cream, and Butter Supplies, and How it should be Applied," makes the assertion that the whole world is suffering greatly because of a lack of adequate practical application of information in regard to this subject.

There is not a package of milk or cream, or a pound of butter sold today that is as good as it can be made, according to Dr. Kitchen, because of (1) the *uncertainty* that exists in regard to the character of all such products as to infections and toxic contamination, and (2) the *certainty* that all such products are more or less contaminated with putrefactive products. There is no wonder, he says, that these products lack the highest attainable gustatory excellence, or that pediatrists have so little "luck" with bottle-fed babies.

He believes that the preservation of all milk by holding it in insulated containers at temperatures sufficiently high to inhibit bacterial activity will, in the future, replace the use of intensely cold temperatures on which dependence is now placed, and suggests, as a measure to solve the troubles incident to a lack of uniformity in the production of milk throughout the year, the condensing of surplusage during flush times, coincidently driving off volatile contaminants, and holding the product by deep refrigeration. The milk thus held would be reconstituted by adding sterile water, the milk being distributed at a temperature but slightly above the freezing point.

Sanitation Plus

Pasteurization is effectual in the preservation of milk when all the residues of bacteria and spores are destroyed by heat, but Professor W. Paul Heath argues that more than the purely sanitary point of view is to be considered. Food values suffer both under heat and under long refrigeration, says Professor Heath, and everyone knows what happens to temperature control during distribution and after the product gets into the hands of the consumer. In an address before the annual meeting of the Pacific Ice Cream Manufacturers, in Portland, Ore., recently, Professor Heath declared that safety is assured and all dangers from fermentation obviated by the simple method of substituting sterile carbon dioxid for the bacteria-laden air which is a constant source of contamination in milk, butter, and ice cream. In extensive research which included a study of minute chemical changes which affect the flavor of ice cream and other milk products, Professor Heath found that important changes, heretofore too little considered, may result from air contamination. In a cubic foot of air analyzed by the board of health of Chicago, more than 700,000 particles of dirt were counted.

Organic poisons from workmen's lungs, body odors, molds, and dusts of all kinds need to be kept out of ice cream, butter, and dairy products if they are to be preserved without loss of flavor or food value. Dairy products contain air bubbles varying from 10 per cent of the volume of butter to 50 per cent of the volume of ice cream, and the period of its purity (and safety) depends upon the bacterial count of the imprisoned air bubbles. The period of bacteria incubation becomes of no importance only when this air-borne contamination can be excluded.

Vacuum processes having failed, the experimentation of Professor Heath led him to replace the air content with sterile, non-oxidizing carbon dioxid, which led to the development of his process of purification and preservation applicable to the churning of butter, the mixing of ices and ice creams, and the packing of milk products in a clean, non-oxidizing atmosphere which results in a sterile product. In a series of tests, air churned butter showed from ten to two hundred times the bacterial count of the carbon dioxid product, the count varying with the conditions of manufacture.

It is interesting to note in this connection that in the beverages notable for their keeping qualities the yeast has liberated bubbles of carbonic atmosphere, while even a thimbleful of air will cause a quart of fruit to spoil on the pantry shelf. Further developments of interest may be considered as assured, for so simple and effectual a means of food preservation, fully commercialized, makes possible the storing and shipment of hitherto highly unstable food products in perfect condition.

Y. W. C. A. STARTS MOVEMENT TO BROADEN NURSES' HORIZON

The Y. W. C. A. has started a "Come Out in the World" movement among student nurses. As one objection to the profession has been that it gives no opportunity for the broad influences of the outside world, this movement is perhaps filling a real need. One phase of it is the admitting of student nurses to the summer conferences of the Y. W. C. A. The nurses have availed themselves of this privilege with enthusiasm, and the training schools report a very beneficial result in all cases.

Another phase of the movement is the establishing of branches of the Y. W. C. A. at training schools. This was done at the University of California Hospital Training School with great success. At the end of the first year the organization boasted a 90 per cent membership, and everyone in the school was delighted with the difference it had made in the spirit of the student body.

ROCKFORD HOSPITAL OPENS NEW DEPARTMENTS

The Rockford Hospital at Rockford, has recently opened up an out-patient department with sick baby, orthopedic, medical, surgical, eye, ear, nose and throat, and venereal clinics.

A complete record system has also been introduced. The staff has gone on record as adopting the Class A hospital organization recommended by the American College of Surgeons. A thoroughly equipped modern laboratory with facilities for performing all types of physiological, sereological, bacteriological, and pathological work has just been installed, and Dr. W. T. Cluney, formerly of Northwestern University and Wesley Hospital, Chicago, has been employed as director. The installation of this laboratory has been made possible through the generosity of Mrs. Walter A. Forbes who purchased the equipment as a memorial to her father and mother.

INDIANA HOSPITAL ASSOCIATION JOINS NATIONAL BODY

The application of the Indiana Hospital Association for membership as a geographical section of the American Hospital Association was presented recently to the board of trustees and unanimously approved. The Indiana Association is the fourth state association to become a geographical section of the national association.

THE USE OF CERTIFIED MILK IN THE HOSPITAL

By C. W. MUNGER, M.D., Superintendent, Columbia Hospital, Milwaukee, Wis.; Executive Secretary, Wisconsin Hospital Association

THE public has the right to presume that the milk supply of any hospital is safe. The very nature of the institution precludes, in the mind of the layman, the possibility of carelessness in this regard. In how many hospitals, however, is the milk handled more carefully than in the ordinary hotel or restaurant?

The writer has been interested in observing the facilities for handling milk in the hospitals which he has visited in various parts of the country. It is inspirational to observe the methods of milk handling and milk modifying at such institutions as the Hospital for Sick Children, Toronto, or the Peter Bent Brigham Hospital, Boston. It is a far cry from this state of affairs to that of the hospital which takes its milk as the dairyman chooses to furnish it, and exercises no supervision whatever over the manner in which it is handled thereafter.

The writer's hospital started making routine bacteria counts on milk for general use, about two and a half years ago. Previous to that time the only counts which had been made were occasional ones on the certified milk which was used for the very few feeding cases which were handled.

Dairy Bacteria Count Very High

In January, 1919, five patients in different parts of the hospital developed as a complication of the diseases for which they were being treated, fairly severe cases of diarrhea with fever. In searching for the cause of this small epidemic, investigation of the milk supply was naturally made. Bacteria counts were taken from the supply received from the two dairies with which the hospital was dealing at that time. The laboratory reported the shocking news that the pasteurized milk of one dairy had a count of 1,700,000 per c.c.—that of the other dairy was 65,000.

The cause of the epidemic was immediately plain. Dairy number one was notified at once and did not seem greatly surprised at the report. A small amount of their milk was still bought daily and the bacteria counts continued—they remained high. After a third notification of the dairy and a threat to appeal to the city health department, this dairy improved its methods so that its pasteurized milk now has a count usually below 100,000.

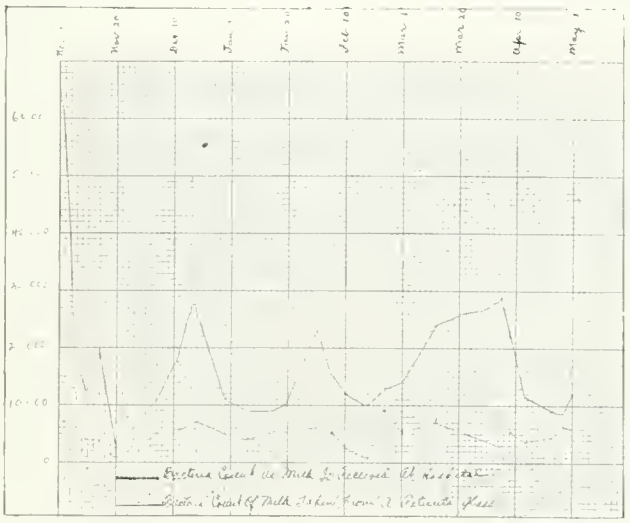


Chart showing bacteria counts of certified milk used by Columbia Hospital, Milwaukee, Wis.

Bacteria counts were continued and it was found that dairy number two had occasionally a rather high count. The clinical records of the patients were watched with special care at the time the bacteria counts were up, and it was found that at those times there were likely to be slight cases of enteritis, occasionally even a nurse reporting herself unfit for duty because of this trouble.

The only conclusion which could be drawn from these results was that pasteurized milk as furnished by the best dairies in the city of Milwaukee was a rather uncertain quantity, and that while it might rarely cause trouble to healthy individuals, there was a decided hazard in feeding it to sick people.

Certified Milk Used

The natural course was to use certified milk for patients. The barrier to this procedure was the high cost of that product. Certified milk was selling at twenty-six cents per quart, put up in pint or quart bottles, and bearing the cap and seal of the Milwaukee Medical Society.

In October, 1920, a representative of the hospital attended a meeting of the Milwaukee Milk Commission, held at the Brook Hill Certified Dairy in Waukesha County. On the suggestion of the representative of the hospital and of Mr. Howard Greene, Jr., owner of the dairy, the commission agreed that an experiment might be made. This experiment provided for the delivery of certified milk to hospitals only, in an especially designed mushroom topped, five gallon can. This can is placed in a wooden casing containing sufficient ice to last until it is delivered. The hospital receives milk from the night milking before 6 a. m. The importance of this arrangement is in the fact that the dairy can supply the milk at ten cents less per quart because of the greater economy in handling. The present bulk price is fourteen and a half cents per quart.

The following procedure is followed by Columbia Hospital in caring for its milk supply. The hospital has ten gallon urns, which are constructed somewhat on the order of the thermos bottle, and are also refrigerated. Previous to the introduction of the milk, the urns, which are seamless, are thoroughly scrubbed, rinsed with boiling water, subjected to live steam, and again rinsed with boiling water. The float which keeps the fat content of each glass of milk constant, and all other removable parts, are boiled. The urn is then ready for filling.

Great care is taken in emptying the milk from the can. The mushroom top keeps the lip of the can from becoming contaminated, so the milk does not pour over a dirty surface, as is likely to be true with the usual type of can. As soon as the top is removed, the bacteriologist takes a specimen for the count. The milk is then emptied into the urn and is used as needed during the day. This first bacteria count, as will be shown later, has been uniformly low. It is not enough to have the bacteria count low, merely when the milk is received, for it must be realized that the count can be multiplied many fold in the course of

a few hours. A second count of the milk is therefore taken, *from a patient's glass*, after the milk has been in the urn for half a day.

These two counts yield considerable information. The first count checks the quality of the milk as delivered by the dairy. Any elevation is reported back to the dairy at once and is compared with counts which the dairy itself makes. On the other hand, when the first count is between two and ten thousand and the second goes above twenty thousand, we look into the process of sterilizing the urns, because carelessness here will often cause count number two to be elevated. It has been necessary to check back on the work of the hospital in sterilizing the urns much more frequently than it has been necessary to report to the dairy. As will be noted from the accompanying chart, count number one has never been above 15,000. Count number two was sixty thousand on the first day, when the employees did not realize the necessity of great care in handling milk. Since then, count number two has occasionally been above twenty thousand and has yet to go above thirty thousand.

These statistics have been very interesting to compile and it has been very gratifying to note that enteritis complications among patients have been practically nil since certified milk has been used.

It is believed that the Milk Commission of the Milwaukee Medical Society made no mistake in altering its rule that certified milk could be delivered in quart containers only. The hospital is pleased with the arrangement because it improves the welfare of its patients. A small pasteboard cover, on which is printed "We serve only certified milk; its purity is verified by frequent tests made in our own laboratories" is used for each glass of milk, so that the patient is informed as to the kind of milk he is drinking. The patients are interested and pleased that their better interests are so carefully guarded.

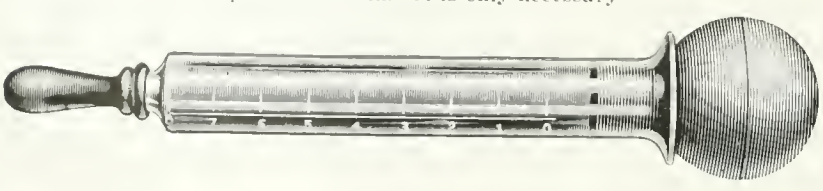
Summary

1. Provide properly refrigerated milk urn.
2. Properly sterilize this milk urn daily.
3. Make a bacteria count on the milk as received at the hospital.
4. Exercise infinite care in transferring milk from milk can to urn.
5. Make second bacteria count after milk has been in urn for several hours.
6. See that milk goes directly from urn to patient, when possible.
7. Milk sent in containers to wards to be handled aseptically.
8. Daily medical inspection of persons who have any contact with the milk supply.

HERE IS A NEW INFANT FEEDER

A new feeder for weak and premature infants has recently been introduced. It has a capacity of one ounce and is graduated in eight parts, each part representing one dram. The bulb fits into and not over the syringe barrel, and is very much easier to remove and attach, whenever this is necessary for the purpose of sterilizing.

The feeder will also be found very useful for removing the cream from the top of cow's milk. It is only necessary to remove the nipple, compress the bulb, insert the tip of the feeder into the milk bottle and draw the excess cream into the glass barrel.



COMPLETE FOOT PRINT OUTFIT

A very definite hospital problem, particularly for maternity institutions, has been the proper identification of babies. The Chicago Lying-In Hospital was probably the first to devise the foot print method as one of the very definite means of identification. Authorities agree that one method of identification is not sufficient and that two or even three different methods should be followed to insure absolute security. As a result of publicity given the foot print method, as adopted by the Chicago Lying-In Hospital, a manufacturer has recently introduced a complete outfit, including all necessary material for the making of foot prints. The routine in this permits making one foot print for hospital record and giving the patient a duplicate copy.

BEWARE OF OVERWORKING YOUR NURSES

The Hospital lately printed this appeal: "The ideal arrangement is for the nursing service to be drawn closer and closer within the sphere of the Ministry of Health. The state nursing service, like the state medical service, is the dream of the future. But in the present we are confronted with a host of problems, none of which can be solved without the aid of skilled nurses. At every point in his plans the Health Minister is constrained to pause and reckon out what nursing aid he can depend on. Unless he is backed by a well regulated, well paid, and contented body of nurses, his activities in every single department will be perforce curtailed. The habit of overworking nurses is ingrained in the mind of the public, notwithstanding all the indignation they are ready to manifest when facts are brought home to them. Nurses need protection by law from the very instincts of their vocation which prompt them to self-sacrifice for the sick. Without this safeguard, the public will go on exploiting them, for none are so utterly stony-hearted as those who see their friends suffer and look to the nurse to bring relief; none are so forgetful of the claims of Nature as nurses can be in the hour of another's need."

The new probationer was carrying a glass of water to a patient, when the latter gasped:

"Oh, I'm going to faint!"

Very excited at this first emergency, the nurse replied:

"Please wait just a minute till I call the head nurse!"

MEETINGS, CONVENTIONS AND CONFERENCES

TENTATIVE PROGRAM OF AMERICAN HOSPITAL ASSOCIATION

THE president of the American Hospital Association has prepared the following tentative program for the forthcoming convention, to be held at West Baden, Ind., September 12-16, 1921. It will be noted that the program is not complete as to all of the sections, and it is, of course, subject to changes in the future.

Monday, September 12, 1921

2 P.M. Registration.
Formal opening of the exposition.
8 P.M. Reception, music and dancing, atrium of the hotel.

Tuesday, September 13, 1921

10 A.M. Opening session, Convention Hall.
President Baldwin presiding.
Address of Welcome.
By Governor W. T. McCary of Indiana.
President's Address.
By L. B. Baldwin, M.D., Superintendent of University of Minneapolis Hospital, Minneapolis, Minn.
Report of the Trustees.
Report of the Executive Secretary.
Report of the Membership Committee.
Routine opening business.
"What Salaries Are Hospital Superintendents Receiving?"
By Joseph J. Weber, Managing Editor, THE MODERN HOSPITAL, Chicago, Ill.
Appointment of Committees.

2 P.M. General Session, Convention Hall.
President Baldwin, presiding.
"The Development of Good Professional Work in the Hospital."
By Charles S. Woods, M.D., Superintendent Methodist Episcopal Hospital, Indianapolis, Ind.
Discussion.

3 P.M. Round Table, Convention Hall. (Following the above.)
Conducted by M. T. MacEachern, M.D., Superintendent, Vancouver General Hospital, Vancouver, B. C.
"What Constitutes Good Service to the Patient"?

8 P.M. General Session, Convention Hall.
President Baldwin, presiding.
A single special speaker. (To be announced.)

Wednesday, September 14, 1921

10 A.M. Dispensary Section, Convention Hall.
John E. Ransom, Chairman, Superintendent, Michael Reese Dispensary, Chicago, Ill.
Clarence E. Ford, Secretary, Superintendent, Division of Medical Charities, New York State Board of Charities, Albany, N. Y.
Program. (Not yet announced.)

10 A.M. Hospital Construction Section, Moving Picture Hall.
George O'Hanlon, M.D., Chairman, Superintendent, Bellevue Hospital, New York City.
Oliver H. Bartine, Secretary, New York City.
Program. (Not yet announced.)
Round Table.
Conducted by the Chairman.
Hospital Construction Problems to be presented and discussed.

Wednesday, September 14, 1921

2 P.M. Section on Social Service, Assembly Hall.
Ruth V. Emerson, Chairman, Secretary, American Association of Hospital Social Service Workers, Washington, D. C.
Program. (Not yet announced.)

2 P.M. General Round Table, Convention Hall.
Conducted by A. C. Bachmeyer, M.D., Superintendent, Cincinnati General Hospital, Cincinnati, Ohio.
Administrative Problems to be presented and discussed.

3 P.M. General Round Table, Convention Hall.
Conducted by John E. Ransom, Chairman of Dispensary Section, Superintendent, Michael Reese Dispensary, Chicago, Ill.
Dispensary Problems to be presented and discussed.

8 P.M. General Round Table, Convention Hall.
Conducted by Asa S. Bacon, Superintendent, Presbyterian Hospital, Chicago, Ill.
Department Problems to be presented and discussed.

8 P.M. Section on Administration, Assembly Hall.
A. C. Bachmeyer, M.D., Chairman.
C. G. Parnell, M.D., Secretary, Superintendent, University Hospital, Ann Arbor, Mich.
"How Hospital Records can Contribute to Health Protection."

By Haven Emerson, M.D., Medical Adviser, and Assistant Director, Bureau of War Risk Insurance, Washington, D. C.

Thursday, September 15, 1921

10 A.M. Section on Nursing, Convention Hall.
Mary M. Riddle, R.N., Chairman, Superintendent, Newton General Hospital, Newton Lower Falls, Mass.
Jessie C. Catton, Secretary, Superintendent, Lawrence General Hospital, Lawrence, Mass.
Program. (Not yet announced.)

10 A.M. American Hospital Conference (Open Session), Assembly Hall.
Frank Billings, M.D., President, Professor of Medicine, University of Chicago, Chicago, Ill.
Program.
Report and Remarks.
By Frank Billings, M.D., President.
Report of the Hospital Library and Service Bureau.
By Donelda R. Hamlin, Director, Chicago, Ill.
Report of the Treasurer.
By Harry E. Mock, M.D., Treasurer, Chicago, Ill.
Report of the Trustees.
By A. R. Warner, M.D., Acting Secretary, Chicago, Ill.
Report of the Special Committee to work out the procedure in the determination of policies as to hospital service.
Election of Officers.

2 P.M. Joint General Session, Convention Hall.
Frank Billings, M.D., President of the Conference, presiding.
American Conference on Hospital Service.
American Hospital Association.
Address
By John G. Bowman, M.D., Chancellor of the University of Pittsburgh, Pittsburgh, Pa.
Discussion.
"A Method of Increasing Medical Efficiency Within the Hospital."
By Franklin R. Nazum, Medical Director, Santa Barbara Cottage Hospital, Santa Barbara, Cal.
Discussion.

8 P.M. General Session, Convention Hall.
President Baldwin, presiding.
Presenting Reports of Activities of the Association.
Report of the Special Committee Studying Flooring Materials for Hospitals.
By Frank E. Chapman, Chairman, Director, Mount Sinai Hospital, Cleveland, Ohio.
Report of the Special Committee on the Subject of the Relation Between the Hospitals and the State and City.
By John E. Ransom, Chairman.
Report of the Special Committee Studying Hospital Forms and Records.
By A. C. Bachmeyer, M.D., Chairman.
Report of the Special Committee for the Study of State Subsidy for Hospitals.
By Howell Wright, Chairman, Secretary, Cleveland Hospital Council, Cleveland, Ohio.
Report of Progress from the Special Committee Studying the Education of the Hospital Social Worker.
By Michael M. Davis, Jr., Chairman, Executive Secretary, Committee on Dispensary Development, New York City.

Friday, September 16, 1921

10 A.M. Section on Dietetics and General Session, Convention Hall.
Lulu Graves, Chairman, Mount Sinai Hospital, New York City.
Marion Peterson, Secretary, Chief Dietitian, Swedish Hospital, Minneapolis, Minn.
"Food Preservation."
By John Phillips Street, National Canners' Association, Indianapolis, Ind.
"Practical Suggestions for Hospital Dietary Departments."
By Rena Eckman, Chief Dietitian, University Hospital, Ann Arbor, Mich.

11 A.M. General Session, Convention Hall.
President Baldwin, presiding.
"Cooperative Purchasing by Hospitals."
By Guy J. Clark, Purchasing Agent, Cleveland Hospital Council, Cleveland, Ohio.
Round Table.
Conducted by Guy J. Clark.
Purchasing Problems to be presented and discussed.

10 A.M. Trustees' Meeting, Assembly Hall.

10 A.M. American Conference on Hospital Service (Executive Session).

2 P.M. General Session, Convention Hall.
President Baldwin, presiding.
"Where to go for Money."
By R. M. Bradley, Trustee, Thompson Trust, Boston, Mass.
Discussion.
Closing Business.
Reports of Committees.
Constitution and By-Laws.
Resolution.
Time and Place.
Auditing.
Nominating.
Special.
Election of Officers.
Adjournment.

LEAGUE FOR CONSERVATION OF PUBLIC HEALTH MEETS

The annual hospital conference of the League for the Conservation of Public Health of California was held at San Francisco on June 24 and 25, 1921. The purpose of the conference, which was attended by hospital directors, superintendents, nurses, physicians, surgeons, dentists, architects, and others interested in hospital problems, was to enable hospitals to enlarge their field of public service and to promote better institutions. The subjects of debate were various, among them being: 'The Hospital and the Public," "The Location and Construction of Hospitals."

INDIANA HOSPITAL ASSOCIATION TO ACT AS HOST

The Indiana Hospital Association will act as host to the American Hospital Association at its meeting at West Baden, and representatives of this state association will be in charge of the bureau of information, which will be situated near the registration office in the West Baden Springs Hotel.

CATHOLIC HOSPITAL ASSOCIATION RE-ELECTS FATHER MOULINIER PRESIDENT

IN HIS sermon at the opening session of the Sixth Annual Convention of the Catholic Hospital Association, held at St. Thomas College, St. Paul, Minn., the Most Rev. Austin Dowling, D.D., Archbishop of St. Paul, traced the historical development of the hospitals from the time when their only work was charitable work, and all of their patients ward patients, to the present time of highly complex work and construction. He warned his hearers of the danger of losing the spirit of charity in the midst of the scientific work of the present day, and in the midst of their economic efforts to enlarge their work and equipment, and meet the expenses involved in this expansion.

The Archbishop's sermon was delivered in the Chapel of St. Thomas College on Tuesday morning, June 21, and was preceded by mass, the celebrant being the Very Rev. Humphrey Moynihan, A.M., D.D.

The Convention was formally opened by an address of welcome by Dr. W. J. Mayo of the Mayo Clinic, Rochester, Minn. Dr. Mayo touched briefly upon three pressing hospital problems: the rural community hospital, the education of a sufficient number of nurses, and the development of a system of hospital organization which will guarantee medical attention from trained and skilled men of the highest professional attainments.

Rural Medical Facilities a Necessity

Dwelling on the rural community hospital, Dr. Mayo pointed out that the first necessity of life is food; consequently, the farmer is one of the most important factors in our economic life, and adequate medical facilities must be provided to maintain his health. At present the death rate in cities, due to their efficient health departments, hospitals, and nursing facilities, is lower than it is in most rural districts. Doctors, moreover, are choosing cities as their fields of practice because the country districts lack hospitals, nurses, and other facilities necessary for the scientific care and treatment of the sick. This tendency should be corrected by establishing health centers in rural communities which would give the physicians necessary scientific equipment. The establishment of such centers presented a big opportunity, in Dr. Mayo's judgment, for the Catholic Hospital Association and its constituent members.

Dwelling on the shortage of nurses, Dr. Mayo averred that persons of moderate means cannot get a nurse at the price they are able to pay and, therefore, accused society of not making it possible for them to have the nursing care they need when they or members of their families are sick. Various efforts to increase the number of nurses have not yet succeeded in meeting expectations.

Dr. Mayo suggested the training of three types of nurses: (1) the graduate of three years, who should have the standing of a college graduate and receive the degree of B.S.; (2) the graduate of two years, who should be regarded as having the standing of a high school graduate; and (3) the group who would be equivalent to graduates from the grammar school.

In speaking on hospital organization, Dr. Mayo said that, while opening the hospital's doors to all physicians may indicate a broadminded position, the hospital had to guarantee its patients the best medical and surgical skill the community was capable of furnishing. This could be done only through a well organized medical and surgical staff. The burden of selecting this staff should be placed on the shoulders of the staff itself.

Following Dr. Mayo's address, the Rev. Charles B. Moulinier, S.J., Marquette University, Milwaukee, Wis., read his address as president of the Association. It was devoted to a discussion of "The Understanding Heart of the Hospital," in which he made a plea that doctors and nurses should think of their patients as human beings and not merely as "cases." To fail to do this means that they are lacking in the understanding heart. The health of the patient must be looked to, but unless those who work in hospitals reach deeper into the life of the patient, they fail in their duty to the patient, to the race, and to God. Dr. Moulinier pointed out that at the base of the whole hospital problem there lies the simple virtue of honesty.

The second session of the conference was devoted to a discussion of various aspects of the Sisters' hospitals. The first paper, on the "Religious Aspects of the Sisters' Hospitals," was read by the Rev. John P. Boland, D.D., D.C.L., Buffalo, N. Y. Father Boland touched on the historical relationship between the church and medicine, pointing out that in the earlier days of the hospital the religious object was the chief object—so much so that the French named their hospitals "*Hotel Dieu*."

Catholic hospitals, he said, have always regarded their chapels as the center of their activity, and stressed the spiritual care which must go hand in hand with physical care. It is this emphasis on the spiritual which explains the tireless, whole-souled, sunny service which the Sisters render the sick. He made a plea for greater cooperation between the priests and the physicians, on the ground that religious influences are often essential to physical recovery.

Suffering Has Certain Uses

Speaking on "The Ethical Phases of Sisters' Hospitals," Rev. P. J. O'Donnell, Ph.D., Tomkins Cove, Rockland County, N. Y., maintained that suffering has certain definite psychological, social, and moral uses. Psychologically, it makes for strength of will; socially, it breaks down individual isolation and answers the call of kinship; and morally, it takes the mind from the material things of life and furnishes opportunity for atonement. Dr. O'Donnell felt that the ethical atmosphere of the hospital was a decided help to those patients who find it hard to become adjusted to their new environment. He also felt that the routine of the hospital tends to lessen interest in its work, that unconscious habits take the place of intelligent interest, and that the religious life has a marked influence in inhibiting this stagnation.

Dr. Edward Evans, La Crosse, Wis., read a paper on "The Scientific Spirit of Sisters' Hospitals," in which he pointed out that the scientific spirit was an inherent quality of the mind, which recognizes no race, garb, or creed, and that the scientific character of the work of each hospital depends on the training and character of its Sisters, nurses, and medical men.

Sister Alexius Discusses Hospital Management

The final paper of this session was read by Sister Rose Alexius, Good Samaritan Hospital, Cincinnati, O., the subject being "Principles in the Control and Management of Sisters' Hospitals." The management of a hospital

was pointed out as a government within itself, functioning like any other government. It must have a responsible head, who possesses an intimate knowledge of the hospital's work. The hospital should be so organized as to be efficient without doing violence to its personal human element. Divided authority weakens responsibility. She expressed the hope that the Catholic Hospital Association would shortly have its own purchasing bureau. She felt that periodical meetings of the Sisters would prove an aid to the management. The medical staff should exercise great care in inviting new men into its membership, selecting only capable, conscientious, studious men, and excluding self-seekers and those who would be sources of dissension. She suggested the organization of lay boards to look after the material and financial affairs of the hospital, their authority and scope of economy to be well defined. The central control, however, must remain in the keeping of the Sisters, whose purpose should be to bring the hospital up to the highest point of efficiency.

The papers of the morning were discussed by: Rev. P. J. Mahan, S.J., Chicago, Ill.; Dr. E. L. Tuohy, Duluth, Minn.; Dr. J. W. Riley, Oklahoma City, Okla.; and Dr. E. F. Root, Salt Lake City, Utah.

Code of Principles Adopted

At the opening of Wednesday morning's session, Rev. M. P. Bourke, diocesan superintendent of hospitals, Detroit Diocese, Ann Arbor, Mich., who served as chairman, urged the Association to take some official action on the moral principles that bear on medical practice, and after an animated discussion, the code of principles formulated and reported upon by a committee of the Association two years ago was adopted at a tentative minimum, subject to an imprimature. Father Bourke also urged the Association to adopt a definite system of records—forms, indices, and nomenclature.

"Local Anesthesia" was the subject of an illustrated paper by Dr. Robert Emmett Farr, Minneapolis, Minn. Dr. Farr pointed out that local anesthesia is important because everything it demands and permits is compatible with the best interests of the patient. It demands that the psychic treatment of the patient begin at the hospital's office door, that the patient be regarded as a human being, and not merely as a case. A carefully formulated plan of action must be decided upon in order to bring the patient to the operating room in the right state of mind; he must have confidence in the surgeon and in his method, thereby avoiding unnecessary anguish. His physical comfort must also be looked after. Local anesthesia demands an accurate diagnosis before an operation is begun. Its technique is not easy; to use it successfully, one must use it daily. Dr. Farr concluded his paper by showing some interesting pictures which illustrated the unruffled, even happy, frame of mind of patients who were undergoing major operations under a local anesthetic.

Rural Health Centers Advocated by Dr. Jermain

Dr. Louis F. Jermain, Milwaukee, Wis., spoke on the "Position of the Internist in the Hospital, from the Standpoint of the Internist," making a plea for more and better medical service for rural communities. He asserted

Delegates and guests of the Catholic Hospital Association gathered in front of the

that the death rate in rural communities is now nearly as high as in the densest population of our largest cities, and suggested, as a partial remedy for the present deplorable situation, the establishment of small but well equipped and well manned rural hospitals as health centers, organized to render the major services of medicine, surgery, obstetrics, and laboratory work. Such hospitals, he thought, would attract young medical men, who should cooperate with the physician of the surrounding community. In organizations of this type, young internists could secure training in teamwork. It is the duty of the internist, in Dr. Jermain's opinion, to make the general physical examination, sum up the findings of various specialists, determine the operative risks, and give his prognosis. This type of organization makes the hospital a health center in the true sense of the word.

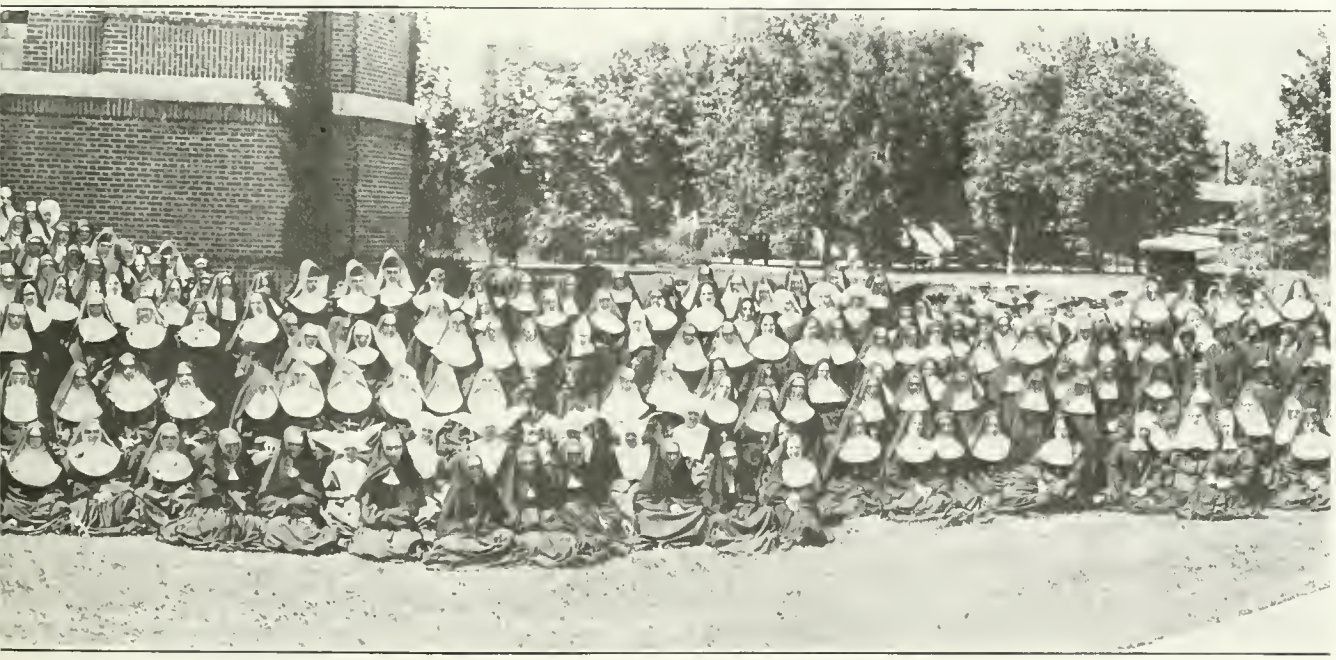
Speaking on the "Importance of the Internist's Position in the Hospital, from the Standpoint of the Surgeon," Dr. Hugh McKenna, Chicago, Ill., said that the hospital of today should be a diagnostic center. He regretted the tendency to treat by surgery cases that can be treated medically, and the incomplete methods of diagnosis, which resulted from the ease of diagnosis on the operating table. Incidentally, Dr. McKenna paid a glowing tribute to Dr. Frank Billings, as a master scientific clinician. He stated that physicians should treat individuals rather than diseases, and that a diagnosis should be based on a medical history and a clinical examination made by an internist backed up by laboratory reports.

The session on Wednesday afternoon, was devoted largely to the report of the Committee on the Nursing Problem, which was submitted by its chairman, Rev. Joseph C. Straub, Springfield, Ill. Questionnaires were sent to 338 Catholic training schools, and the report is based on the 123 which were returned. These questionnaires were returned by schools in thirty-five states; 37⅔ per cent came from western schools, 33⅓ per cent from eastern schools. An attempt was made in the first question to determine whether nurses who graduate from schools giving the longer courses incline more to educational, social service, and public health work than to bedside nursing. Of the 123 that replied, fifty-six replied in the affirmative and fifty-eight in the negative, while nine were undecided. Various reasons were given for this inclination, including easier work, shorter hours, etc. One hundred and one schools were opposed to a program favorable to two grades of nurses; sixteen were in favor of this plan; while six did not express themselves.

As to the question of minimum requirements for entrance, a variety of answers was received. Some favored a college course; some four years of high schools; some three, some two, and some one year of high school. All the schools that replied to the questionnaire were in favor of a three year course of training.

One hundred and fourteen schools are opposed to training two grades of nurses in the same school; six were in favor of this plan, while three did not commit themselves.

Fifty-six of the schools were opposed to the eight hour service; sixty-two were in favor of it; while five failed to answer the question.



Chapel of St. Thomas College on the occasion of the Association's Sixth Annual Convention.

Committee Offers Conclusions

The important conclusions of the Committee were these:

1. Although there is a slight majority that think the longer course of training sends nurses into educational, social service, and public health work, the minority opinion registered a large margin of uncertainty.

2. A large majority were against two grades of nurses and thought that the training of two grades in the same school was impracticable. The answers to the questionnaire, therefore, discouraged this means of easing the shortage of nurses.

3. Only a small majority were in favor of eight hour service. Those who opposed the eight hour service thought it would lessen the spirit of service and would be hard on hospitals.

In general, the Committee felt that the situation could be improved only by a change in the present economic conditions.

The Committee made the following recommendations:

1. As a minimum educational requirement, the Committee favored one year of high school or its equivalent, and at least a three year course required for bedside nursing.

2. For educational, social service, and public health work, postgraduate courses should be provided.

3. Scrupulous avoidance of all attempts at the exploitation of nurses by the hospitals.

4. Comfortable, though not necessarily extravagant, living quarters, and the development of a homelike atmosphere.

5. Strict discipline in the school based on sound religious principles.

Should Send Annual Reports to Schools

In discussing this report Dr. L. D. Moorhead, Mercy Hospital, Chicago, Ill., suggested that, in an effort to increase the enrollment of student nurses, the training schools send copies of their annual reports to the various boarding schools of the country, and that priests bring nursing as a profession to the attention of young women in their parishes.

The concluding paper of this session, on "Retreats for Nurses," was read by Rev. Eugene J. Gehl, St. Francis, Wis.

One of the most interesting sessions of the Conference was the doctors' meeting held at St. Paul Hotel, Wednesday evening, under the chairmanship of Dr. H. B. Sweetser of Minneapolis, Minn. Following a description of a typical staff meeting by Dr. Frank D. Jennings of Brooklyn, N. Y., the evening was devoted to a demonstration of a typical medical staff meeting, under the leadership of Dr. C. A. Gordon and Dr. Frank D. Jennings, assisted by other members of the staff of St. Catherine's Hospital, Brooklyn, N. Y., and by invitation, the staffs of St. Mary's Hospital, Duluth, Minn.; St. Joseph's Hospital, St. Paul, Minn., and St. Mary's Hospital, Minneapolis, Minn.

At the Sisters' meeting held that same afternoon at the Auditorium, St. Thomas College, Sister Rose Alexius, the vice-president of the Association, acted as chairman. Two papers were read; one, prepared by Rev. J. V. Bacci, D.D., chaplain, St. Joseph's Hospital, on "Remarks Concerning: Diocesan Superintendents, and Wearing Washable Habits While on Duty," was read by Sister M. Stanislaus, St. Joseph's Mercy Hospital, Mason City, Iowa. The second paper, on "Postgraduate Work for Sisters," was read by Sister M. Domitilla, St. Mary's Hospital, Rochester, Minn.

Thursday morning and evening were devoted to various conferences, the chairmen of which reported the results of conferences at the Friday morning session. The conference of Mothers Provincial and Superior, and superintendents reported it advisable for hospitals to install all labor saving devices, from the point of view of economy of time and material. The conference was opposed to osteopaths and other medical cults, generally, having entrée to Catholic hospitals; physicians, however, should give consideration to the value of some of their therapeutic measures. It opposed turning over delinquent accounts to collectors. It urged small hospitals, in justice to their pupil nurses, to secure affiliation with larger institutions. The elimination of noise in the hospital and the restriction of visitors should receive attention. It urged hospitals to employ efficient help and give them comfortable living quarters; it felt that it is a mistake to employ cheap help. It advised against practicing economy to the detriment of efficient service. It recommended to the Association that consideration be given to small hospitals at the next convention.

The conference of training school and supervisors of nurses reported that in its judgment the authority of the superintendent of the hospital does not extend to the Sisters, except as they are Sister nurses. It felt that weekly conferences of the supervisors should be encouraged, and that the regulations governing the nurses should be explained to them from time to time. The conference felt that student government should be adopted slowly along general lines. The eight hour system was also discussed and approved, although its incorporation in state laws was not encouraged. The conference urged all Sisters to become members of their alumnæ associations.

The conference on operating room nurses urged the Sisters to interest themselves more in anesthesia, taking full courses in this subject when possible.

Medical Staff and Laboratory Must Cooperate

The conference of laboratory directors and technicians reported that, in order to make progress in hospitals, there must be cooperation between the medical staff and the laboratory. The laboratory, it was felt, should in every case report its findings to the clinician, who should interpret them and make the diagnosis. The value of the newer blood chemistry tests was emphasized and it was urged that medical staffs be instructed as to their value. With regard to charges for routine work, it was pointed out that some hospitals have a flat fee, others a fee running from two to five dollars, while still others charge for each individual piece of work done. The combination of the two ideas—a flat fee and a sliding scale—was recommended. On account of the importance of having qualified technicians, it was recommended by the conference that a committee of the Association be appointed to consider the qualifications and training of laboratory technicians.

The conference of supervisors of records recommended that the Catholic Hospital Association appoint a committee on records for the purpose of establishing a uniform record system. The conference felt that no one but the Sister record supervisor should be made responsible for the records; the records themselves to be written by the internists under the supervision of the attending before the expiration of twenty-four hours. It was recommended that the hospital keep the records for all time. The conference urged every hospital to adopt a follow-up system, ranging from six months to five years in cancer cases, every case to be followed up at least once, and oftener, if possible.

The conference of doctors recommended that a clinical research division be established in the Association, and

that interns and the training of interns should receive more consideration, especially from the older men on the staff. The conference also suggested appointing a committee to consider and report: (1) upon the position of the doctor in the Catholic Hospital Association; (2) ways and means of providing more instruction for the doctors in the meetings; and (3) ways and means of transmitting the recommendations of the conference of doctors to the general body.

The conference recommended that any standardization plan adopted by the Association be the Association's own plan and independent of any other association; these standards to include: (1) that each hospital have a well organized staff; (2) efficient records; (3) no division of fees; (4) that the moral laws and standards of the Catholic Church be rigidly adhered to.

Hospital Directors Are Builders

In its report, the conference of diocesan directors pointed out that the hospital directors act as representatives of the Bishop; that their work is constructive; that they are not to be merely inspectors, but builders, in order that difficulties might be remedied, their purpose being the improvement of Catholic hospitals. One of the important duties of the diocesan directors is to head off, with the aid of Sisters, doctors, and nurses, legislation which tends to hamper the growth of hospitals.

The conference of chaplains, retreat masters, and sodality directors recommended that retreats be conducted for nurses by the Sisters, and that the attendance of nurses at daily Mass should be promoted.

On Thursday evening a second meeting for doctors was held at St. Paul Hotel. The opening paper, on "The Practical Value of Electrocardiograph in the Routine of Hospital Work," was read by Dr. John E. Greiwe, Cincinnati, O. He was followed by Dr. H. O. Pollock, Pittsburgh, Pa., who read a paper on "The Practical Value of Basal Metabolism in the Hospital's Work." This session was concluded by a talk on fifty consecutive deaths, with some autopsies, by Dr. Edward Evans, La Crosse, Wis.

While this meeting for the doctors was being held at St. Paul Hotel, the Sisters met at St. Thomas College Auditorium to witness the demonstration of a typical staff meeting which had been held the previous evening before the doctors.

President Traces Growth of Association

The concluding session of the Conference was devoted to the business of the Association. In his report, Father Moulinier, president of the Association, traced the growth of the Catholic Hospital Association since its inception six years ago, and stated that the present outlook of the Association was promising. He suggested the appointment of the following standing committees representing all the orders of Sisters: (1) committee on standards; (2) committee on revision of constitution; (3) committee on ways and means of increasing vocations to the sisterhood and applicants for the nurses' training school; (4) committee on canon law; (5) committee on ethics and national code; (6) committee on religious services and sacrament; (7) committee on sodalities and nurses' retreats; (8) committee on state and provincial conferences; (9) committee on uniformity of records and nomenclature; (10) committee on program and place of next conference; (11) committee on small hospitals; (12) committee on policy, development, and affiliations. He recommended that, in the future, the presidents of the Association should give full time to their work and have full time assistants. He also reported that *Hospital Progress*, the official publication of the Association, was no longer quite so much of a burden.

Rev. J. P. Boland read the report of the diocesan directors, indicating that there are now thirty-two such directors.

State Conferences Organized

In his report on state, district, or provincial conferences, Rev. George A. Metzger, director, pointed out that conferences have been organized in Wisconsin, Illinois, Indiana, Iowa, Ohio, Missouri, and Western Canada.

The resolutions committee recommended the following action: (1) that the Catholic Hospital Association oppose the tariff on imported surgical instruments; (2) that at all future conferences, anyone not a member of the Catholic Hospital Association, or lacking proper credentials, be denied the floor; (3) that the hospitals make greater effort to secure autopsies; (4) that the hospitals be urged to organize social service departments; (5) that all papers to be delivered at Association meetings hereafter be submitted in abstract to the executive board.

The recommendations of the committee were adopted.

A temporary committee, composed of two priests and one doctor, was appointed to act on all matters pertaining to the ethical code, pending the definite establishment of such a code. Its members are: Rev. J. P. Boland, D.D., D.C.L., Buffalo, N. Y.; Rev. M. P. Bourke, diocesan superintendent of hospitals, Detroit Diocese, Ann Arbor, Mich.; and Dr. Darling, Ann Arbor, Mich.

Membership Increased During Year

The report of the secretary-treasurer showed that the present membership is 464 institutional, and 1,550 individual members, an increase during the present year of fifty-one institutional and 260 individual members. This report also showed that *Hospital Progress*, the official publication, is now completely out of debt, in fact, has a small surplus.

Votes of appreciation were given the president and secretary of the Association for their splendid work during the past year.

The president was empowered to appoint the heads of the divisions of diocesan directors, and of state, district, or provincial conferences. He was also empowered to appoint full time assistants at his discretion.

The president reported that at a meeting of the executive board of the Association it was decided that the Association should have its own hospital standards, and that the committee on standards, with some additions, should be reappointed and would meet again about Christmas time to entertain new suggestions. After that time a draft will be made and sent to the Superiors and various groups of Sisters, preliminary to a full report at the next convention.

One of the helpful features of the convention was the exhibit of the Hospital Library and Service Bureau, which was located just across the room from the registration desk. The exhibit included not only the floor plans of many of the recently constructed hospitals, but also a complete index to *Hospital Progress*, the official organ of the Catholic Hospital Association; standard record forms; a list of hospital architects; and material on the standardization of hospitals. A feature that attracted especial interest was the book of records and pictures of the Royal Victoria Hospital of Montreal which was recently presented to the Library by its superintendent, Mr. H. E. Webster.

The following officers were elected: Honorary president, Most Reverend Sebastian G. Messmer, D.D., D.C.L.,

Archbishop of Milwaukee, Wis; president, Reverend Charles B. Moulinier, S.J., Marquette University, Milwaukee, Wis.; active vice-president, Rev. B. H. Mahan, Chicago, Ill.; secretary-treasurer, Dr. Bernard Francis McGrath, A.B., F.A.C.S., Marquette University, School of Medicine, Milwaukee, Wis.

The executive board is: Dr. Louis D. Moorhead, Mercy Hospital, Chicago, Ill.; Rev. M. F. Griffin, St. Elizabeth Hospital, Youngstown, O.; Mother M. L. Dugas, Grey Nuns, Montreal, Canada; Sister M. Veronica, Mercy Hospital, Chicago, Ill.; Dr. F. S. Wiley, F.A.C.S., St. Agnes Hospital, Fond du Lac, Wis.; Sister Rose Alexius, Good Samaritan Hospital, Cincinnati, O.; and Sister M. Madelius, St. Mary's Hospital, Minneapolis, Minn.

A. M. A. NAMES DR. DeSCHWEINITZ PRESIDENT-ELECT

THE meeting of the American Medical Association in Boston, June 6-10, 1921, was next to the largest in the history of the Association. The attendance was 5,500 registered members, which was exceeded by fifty at the Chicago convention in 1918. The attendance at sections was unusually large and the quality of the papers presented was very good. Surgery and its specialties had the largest attendance, as usual, but more than ordinary attention was given to public health questions.

Among the social features were a tea at the Harvard Medical School, and a reception at the Museum of Fine Arts. Excursions to various points of interest, including Harvard College, were arranged. The reception and ball given in honor of the president, and the regular Association golf tournament took place as usual.

On June 6, at the meeting of the House of Delegates, Dr. Dwight H. Murray of Syracuse, N. Y., delivered an address in which he dwelt upon the profession's new conception of publicity. The new idea that physicians should take the public into their confidence in larger measure than they have done he felt is gaining ground. He stated that education in all health matters was the greatest protective measure and that this might be accomplished by the establishing of a medical feature section in the 900 Sunday papers of the country.

Dr. Work Emphasizes Publicity

Dr. Hubert Work, of Pueblo, Colo., president-elect of the Association, made a brief address in which he emphasized the duty of the medical profession to educate the public in the prevention of disease. He felt that the people for whom discoveries had been made were often quite ignorant of them and of their benefits. Medicine should be advertised and popularized. Health authorities and state societies should give more time to this matter. Dr. Work also made a strong appeal for the establishment of a department of health and public welfare in the Federal Government.

Dr. Alexander R. Craig submitted the secretary's report, in which it was stated that the membership of the several constituent associations which constituted the membership of the American Medical Association on May 1, 1921, was 84,971. The Association has been affected in much the same way that other organizations have by the reaction from the patriotic spirit of the war. One of the dangers, according to the report, was the apparent tendency on the part of certain physicians and a few county societies to be dominated by commercial ideals rather than by the standard which the Association had adopted in formulating its principles of medical ethics, of which the first statement was, "A profession has for its prime object the service it can render humanity."

The Committee on Rehabilitation of Ex-Service Men reported that early in March the Committee on Hospitalization of Ex-Service Men of the American Legion, through Dr. Billings, requested a conference with the American Medical Association with the object of securing that Association's cooperation in the improvement of unsatisfactory conditions in the hospitalization and care of ex-service men. A committee was appointed which went to Washington, but later ceased work because Dr. Billings was selected as a member of the Board of Consultation on hospitalization of ex-service men, and it was felt that he could, therefore, represent the committee of the Association, unofficially but effectively.

Council on Health and Public Instruction Reports

Dr. Victor C. Vaughan presented the report of the Council on Health and Public Instruction which stated that the Council had continued to develop its program adopted in 1914, which was: (1) Investigation of existing health conditions with a view to securing accurate information on all phases of the public health situation. (2) Education of the public and the profession by every means within the resources of the Council, in order that the public might understand the advance of scientific medical knowledge, and the possibility of utilizing such medical knowledge in the prevention of disease, and the reduction of the death rate. (3) The crystallization of public sentiment into such practical health laws and ordinances as might be necessary for the conservation of human life.

Dr. Arthur Dean Bevan presented the report of the Council on Medical Education and Hospitals, which stated that the task, begun in 1905, of securing uniform and acceptable standards of medical education had in large part been completed. The accepted American standard was two years pre-medical work in an approved college or university, a four years' medical course, and a year's internship, as high a standard as that of any country. The work of the Council now includes a study of the problems of preliminary education, the undergraduate medical curriculum, the hospital in its relation to clinical teaching and the intern year, graduate medical education and provision for the training of specialists, and other allied questions.

The Council of Health and Public Instruction submitted statistics concerning hospitals and related institutions in the United States. According to these figures there are 2,926 hospitals having more than twenty-five beds each, with a total of 293,825 beds, of which 196,535, on the average, were occupied each day.

On June 7, at the opening meeting, addresses of welcome were delivered by Honorable Channing H. Cox, Governor of Massachusetts, and Honorable Andrew Peters, Mayor of Boston, who were followed by Dr. Hubert Work, giving the president's address. Dr. Work's subject was "Some Medical Problems." He reminded the profession that they had a duty to the community, and through organization, an opportunity to serve it second only to the national government; that they must contribute their quota to the public welfare, for medicine is now recognized as a public service and not something to be hoarded and sold to individuals only.

"Hospitalization is now the first thought of the sick,

partly for professional, chiefly for economic reasons," said Dr. Work. "The public regards the hospital as a public beneficence. The surgeon demands that the hospital shall be a suitable place in which to operate. The physician regards it as a necessary adjunct to the whole scheme of health. We would have the laity taught to see the hospital as a sociological institution, a place of refuge accessible to the well for prophylactic advice, and to the sick for their unrestricted use, instead of a retreat accessible only to those able to pay, operated primarily for profit and not available to all. By the same token, public hospitals must arise for those without accumulated means, who are not paupers; and the church should assume after-care, in the effective dispensation of coordinated charities as sociologic institutions, with medicine as their adjunct. Modernized hospitals can no longer be maintained by fees alone, nor can a university, and for the same reasons. If the state may properly support universities for training the student, and maintain hospitals for the custodial care of its insane poor, or a county may levy a tax for the maintenance of its county farms, logically the state or county may assess itself in order to treat its ambulatory sick, and to provide equipment to keep in earning health its essential human economic factors."

Dr. Work considered the grouping of physicians for the private practice of medicine an expression of community need, but one which can easily be directed to primarily selfish interests. In closing, he made a plea for the spirit of service which has been exemplified by so many great men of the profession.

The election of Dr. George de Schweinitz, professor of ophthalmology of the University of Pennsylvania, as president, places at the head of the Association a leader in medical science whose specialty has received constant emphasis both through his contributions to scientific literature and his social affiliations, and whose achievements have long been a stimulus to his profession. The broader phases of scientific research and medical service should receive a new impetus under Dr. de Schweinitz' leadership.

LOOKING BACK ON THE ANNUAL MEETING OF THE NATIONAL TUBERCULOSIS ASSOCIATION

VIEWED from the point of attendance, enthusiasm, program and action, the Seventeenth Annual Meeting of the National Tuberculosis Association may well be considered the most successful gathering of its kind in the history of the organization. Approximately 1,050 people were registered and a considerable number who attended were not registered. All sessions of the program were enthusiastically attended by large groups. The exhibit, the pageant, and the other additional features of the meeting were well received and highly commented upon.

It would be difficult to summarize in brief space all of the distinctive features of the meeting, but there are five special points of emphasis that deserve prominent mention.

Reorganization Perfected

The reorganization of the National Tuberculosis Association, following lines recommended by the committee on reorganization, of which Dr. David R. Lyman was the chairman, was finally perfected at this meeting. The board of directors was expanded from sixty to 103, consisting of a representative director for each of the fifty-three state and affiliated associations and fifty directors at large. The National Tuberculosis Association now becomes, to some extent at least, a federation of state associations. Each state and affiliated organization has its own state representative on the board. The absence of sectionalism, however, in the first meeting of the board of directors was a cause for particular gratification to all who were interested in this phase of the annual meeting.

Another point of emphasis at the annual meeting was the stress laid upon more continued medical and social research. Dr. Webb in his presidential address sounded the keynote of the entire meeting when he said, "We must frankly state our knowledge of tuberculosis and also the extent of our ignorance regarding it, so that we can more wisely guide the efforts made in prevention and cure, and direct research to bring further enlightenment. . . . While the Association is teaching, it should also be learning."

The emphasis of the meeting upon the problem of tuberculosis in children was also manifest. The subject of nutrition was given a prominent place on the program and was ably presented by Dr. W. R. P. Emerson of Boston. The Modern Health Crusade came in for a prominent place in the discussion. The educational exhibits as well as other features of the conference all contributed toward the general impression that the child is the focal point at the present time for the anti-tuberculosis movement. This impression was strengthened by the reports presented at the pathological session of work done in the laboratory.

From several different angles of approach, the declining death rate of tuberculosis was discussed and emphasized. Dr. Frankel's emphasis in his paper on statistical evidence of intensive anti-tuberculosis effort upon the death rate clearly showed that where the tuberculosis program has been properly emphasized and where the results can be adequately measured, there is evidence to show that results are forthcoming in a decreased death rate.

Ex-Soldier the Most Difficult Problem

In one whole session of the advisory council on Tuesday night, and in other sessions of the meeting, the problem of the tuberculous ex-service man was taken up. As Dr. Lyman pointed out and as the resolutions adopted by the Association clearly stated, the tuberculous ex-service man presents not only the most difficult single problem of its kind this country has ever faced, but it also presents a broader and more serious problem in public health as well. "Summed up somewhat tersely," said Dr. Lyman, "the possibilities are the greatest, perhaps, we have ever had, while the limitations are at present so great as to make a successful solution under existing conditions appear almost impossible."

Probably the most significant of the special features was the pageant staged on Thursday night, which was entitled "The Spirit of the Double Barred Cross." Of the thousand or more people who saw the pageant, none could help but be inspired as well as instructed. It dealt with the sweep of the campaign against tuberculosis from the discovery of the stethoscope by Laennec to the rapidly

advancing Modern Health Crusade of the present time. The spirit of the Crusade depicted in the death and return of King Arthur in two matchless scenes added not only color and allegory to the pageant, but supplied inspiration as well to all who were present.

Several important resolutions were adopted by the Association.

Concerning medical education, it was resolved that the medical schools of the country be urged to take account of the establishment of tuberculosis departments in their curriculums, and that new sanatoriums be located with a view to making their facilities available for the development of such departments.

Need Better Discipline in Hospitals

The Association felt that the rehabilitation of ex-service men was its most imperative duty, and that at present the best results were not being attained because of a lack of discipline, and resulting poor morale among the men. It therefore resolved to urge Congress to give the government departments the necessary assistance to establish this discipline. It was further resolved to commend the efforts of the national officials of the American Legion to correct the defects in legislation pertaining to the rehabilitation of ex-service men.

The Association approved the principles involved in sheltered training and employment for tuberculosis, and recognized the provision of such employment as an important part of the tuberculosis problem.

It was resolved to ask the United States Public Health Service to detail medical examiners especially trained in tuberculosis work to be stationed at ports of debarkation, and also to encourage steamship companies to have some type of examination at the port of embarkation.

A resolution was passed in appreciation of the great services of General William C. Gorgas, whose death during the year was such an irreparable loss to the Association as well as to the world.

The Conference expressed itself not in favor of the suggestion of caring for the incipient or favorable cases in separate wards of general local hospitals, although it has always advocated that advanced cases be cared for in this way.

Elect Officers

The following officers were elected at the meeting of the board of directors held June 15: president, Dr. James Alexander Miller, New York; Honorary vice-presidents, Hon. Warren G. Harding, Washington, D. C., and Col. George E. Bushnell, U. S. A., retired; vice-presidents, Dr. Lawrason Brown, Saranac Lake, N. Y., and Dr. Ralph Matson, Portland, Ore.; secretary, Dr. George M. Kober, Washington, D. C.; treasurer, Mr. Henry B. Platt, New York City. Executive Committee: the president, the vice-presidents, the secretary and the treasurer ex-officio; and Dr. William Charles White, Pittsburgh, Pa.; Dr. H. Kennon Dunham, Cincinnati, O.; Dr. Alfred Henry, Indianapolis, Ind.; Dr. W. L. Dunn, Asheville, N. C.; Mr. Homer Folks, New York City; Dr. David R. Lyman, Wallingford, Conn.; and Mr. Sherman C. Kingsley, Philadelphia, Pa.

The following is a list of the directors of the Association elected at the annual meeting:

Alabama
Mrs. H. E. Pearce, Birmingham

Arkansas
Col. Kenneth P. Williams, Little Rock

Arizona
Dr. John W. Flinn, Prescott

California
Dr. Robert H. Peers, Colfax
Dr. W. Jarvis Barlow, Los Angeles
Dr. C. C. Browning, Los Angeles

Colorado
Dr. G. Walter Holden, Denver
Dr. A. M. Forster, Colorado Springs
Dr. Gerald B. Webb, Colorado Springs

Connecticut
Dr. Stephen J. Maher, New Haven
Dr. David R. Lyman, Wallingford
Mr. Wallace S. Allis, Newburgh

District of Columbia
Dr. E. C. Schroeder, Washington
Dr. Livingston Farrand, Washington
Mr. William H. Baldwin, Washington

Florida
Dr. T. Z. Cason, Jacksonville

Georgia
Major R. J. Guinn, Atlanta

Idaho
Dr. Charles R. Mowery, Wallace

Illinois
Dr. J. W. Pettit, Ottawa
Dr. O. W. McMichael, Chicago
Dr. Josephine Milligan, Jacksonville
Dr. James A. Britton, Chicago
Dr. Max Biesenthal, Chicago
Dr. Frank Billings, Chicago
Mr. Morton D. Hull, Chicago
Mr. Julius Rosenwald, Chicago
Dr. Ethan A. Gray, Chicago

Indiana
Dr. Alfred Henry, Indianapolis

Iowa
Dr. John H. Peck, Des Moines
Mrs. F. C. Whitley, Des Moines

Kansas
Dr. Charles H. Lerrigo, Topeka
Dr. S. J. Crumbine, Topeka

Kentucky
Dr. A. T. McCormack, Louisville

Louisiana
Dr. Oscar Dowling, New Orleans

Maine
Dr. E. D. Merrill, Foxcraft

Maryland
Dr. Martin F. Sloan, Baltimore
Dr. William H. Welch, Baltimore
Rev. Charles Hannigan, Baltimore

Massachusetts
Dr. Edward O. Otis, Boston
Dr. Roger I. Lee, Cambridge
Mr. Henry S. Dennison, Framingham
Col. George E. Bushnell, Bedford
Dr. Vincent Y. Bowditch, Boston

Michigan
Dr. A. F. Fisher, Hancock
Dr. William DeKleine, Flint

Minnesota
Dr. A. T. Laird, Duluth

Mississippi
Dr. Henry Boswell, Sanatorium

Missouri
Dr. O. C. Gebhart, St. Joseph
A. W. Jones, Jr., St. Louis

Montana
Mr. H. R. Cunningham, Helena

Nebraska
Dr. William N. Anderson, Omaha

Nevada
Mrs. John M. Fulton, Reno

New Hampshire
Dr. John M. Wise, Glencliff

New Jersey
Dr. S. B. English, Glen Gardner
Dr. B. S. Pollak, Secaucus
Dr. Theobald Smith, Princeton

New York
Mr. George F. Canfield, New York
Dr. E. R. Baldwin, Saranac Lake
Dr. Hermann M. Biggs, New York
Mrs. John M. Glenn, New York
Dr. Lee K. Frankel, New York
Mr. John A. Kingsbury, New York
Dr. George M. Price, New York
Dr. Charles Stover, Amsterdam
Dr. Lawrason Brown, Saranac Lake
Dr. Alfred Meyer, New York
Mr. Hugh Frayne, New York
Mr. Homer Folks, New York
Mr. Fred M. Stein, New York
Dr. James Alexander Miller, New York
Dr. Thomas J. Riley, Brooklyn

North Carolina
Mr. R. B. Wilson, Raleigh
Dr. Charles L. Minor, Asheville
Dr. W. L. Dunn, Asheville

North Dakota
Dr. J. Grassick, Grand Forks

Ohio
Dr. Robert H. Bishop, Jr., Cleveland
Dr. A. C. Bachmeyer, Cincinnati
Dr. H. K. Dunham, Cincinnati

Oklahoma
Mr. J. F. Owens, Oklahoma City
Mr. E. K. Gaylord, Oklahoma City

Oregon
Dr. Ralph C. Matson, Portland

Pennsylvania
Dr. Paul A. Lewis, Philadelphia
Mr. Sherman C. Kingsley, Philadelphia
Dr. Thomas McCrae, Philadelphia
Dr. William Charles White, Pittsburgh
Mr. Edward A. Woods, Pittsburgh

Rhode Island
Dr. D. L. Richardson, Providence

South Carolina
Mr. John P. Thomas, Jr., Columbia, S. C.

South Dakota
Mr. H. M. Cass, Huron

Tennessee
Mr. Henry Teitlebaum, Nashville

Texas
Dr. Z. T. Scott, Austin

Utah
Mr. James H. Wallis, Salt Lake City

Vermont
Dr. Edward J. Rogers, Pittsford

Virginia
Dr. Charles R. Grandy, Norfolk

Washington
Mr. J. V. A. Smith, Seattle
Mrs. R. C. McCredie, Sunnyside

West Virginia
Dr. C. H. Barksdale, Charleston

Wisconsin
Dr. J. W. Coon, Stevens Point
Dr. Hoyt E. Dearholt, Milwaukee

Wyoming
Dr. J. D. Shingle, Cheyenne

Clerk—Wadleigh B. Drummond, Portland, Me.

LAY CORNERSTONE OF MEMORIAL TO AMERICAN NURSES

The cornerstone was laid on June 5, for the Florence Nightingale School for Nurses, at Bordeaux, France, which is to be a memorial to the 284 American nurses who died in the World War. The school is to be built with the 800,000 francs raised by American nurses.

Miss Helen Scott Hay of Havana, Ill., laid the stone for Miss Clara D. Noyes, President of the Nurses' Association, in the presence of a detachment of bluejackets from the American torpedoboat destroyer Childs, Rear Admiral Thomas P. Magruder, representing the American Embassy, American Red Cross officials, French authorities, and French nurses.

"How much does that stylish doctor of yours charge?"

"Ten dollars a visit."

"Gee! How often has he called at your house this month?"

"Twenty times."

"Gosh! You owe him $200, then?"

"Nope; only $10. He's made the other nineteen calls trying to collect it."—*Cleveland Leader.*

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VEGETABLE COLOR
This package makes four quarts of Jell-O. Serves forty to fifty persons according to size of portion
Dissolve the contents of the package in four quarts of boiling water and set in a cold place to harden
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OCCUPATIONAL THERAPY AND REHABILITATION

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THE RELATION OF OCCUPATIONAL THERAPY TO CHRONIC DISEASE*

BY LORING T. SWAIM, M.D., BOSTON, MASS.

There is nothing so much dreaded by the normal man as physical or mental disability. He hates sickness, and dreads the necessity of being inactive. But when sickness comes it speedily robs him of all ambition and courage. In some cases two weeks is sufficient to make him wish never to work again. Therefore, the first lesson to the occupational therapist should be to start work with the patient at the earliest opportunity.

Work is essential to the health both of the body and of the mind. Physically, it exercises the muscles, bones, and joints. It stimulates metabolism, increases circulation, and prevents congestions. Work is necessary for the greatest mental vigor, and for a normal, happy state of mind. Thought is as essential to mental well-being and the building up of the mind as muscular exercise is to the well-being and building up of the body.

IT IS my aim in this paper, if possible, to present occupational therapy from an angle which is of the greatest importance to an orthopedist, and one which, although not new, illumines new fields for invention, study, and appreciation of methods and uses toward better results.

Nothing is so galling to the normal soul as physical and mental disability. The right spirited man fears illness, he loathes weakness, and he detests being inactive. Down in every man's soul is the dread of being a cripple. In spite of this, disease, both mental and physical, very quickly makes him lose hope, faith, and self-respect, until he is willing to sit back and do nothing. The course of this change is not slow, but surprisingly quick and complete. In some cases two weeks is long enough to make some men never wish to work again. Therefore, our first lesson should be to begin work at the earliest possible opportunity.

Work, then, is essential to health. It is as essential for the body as the mind. It is as essential for one sex as the other.

What does work do for the physical body? It exercises muscles, bones, and joints. It stimulates the internal combustion called metabolism. It increases circulation and prevents congestions and toxemias. It stimulates secretion and elimination of waste products. All the involuntary muscles, such as the heart, lungs, stomach, and intestines, are reflexly stimulated by voluntary arm, body, and leg action. The normal circulation of the brain is dependent on normal muscular activity. All the functions of the body, all the cravings of the flesh are increased and accelerated by muscular activity.

Our first statement, then, is true: Work is essential to physical health.

It is unnecessary to state that a normal, happy mind depends on work. For the greatest mental vigor, thought is necessary. Thought builds character just as muscular exercise is the only means to complete physical well-being.

Why do men stop work? Because of: (1) failure to see the importance of it; (2) loss of ambition; (3) lack of strength; (4) pain; (5) lack of stimulation and training; (6) lack of knowledge of what to do when the usual routine is broken up; (7) a mistaken idea that they will do something else, such as play.

For instance, there is the arthritic, who, because of pain, does not do anything. He loses interest, and finally faith and hope, and then becomes down on his luck, and sees no object in painful work of any kind. Then there are the nervous, frail people who lack the vitality to carry out sustained periods of work. They have lost the incentive for accomplishments, the finished result is so long in coming.

You all have seen the patient who enjoyed poor health, in whom neither scolding, persuasion, nor ridicule any longer roused the normal reaction to try. It is, alas, too common. The patient is not entirely to blame, often it is the fault of the physician's ignorance, augmented by the family's lack of faith, and at last carried on by the patient's hopelessness.

We all dislike doing anything for our health. What man walks for his health when he can play golf?

In the study and handling of chronic orthopedic patients there are several definite factors to be considered: the loss of physical tone due to lack of exercise, the abnormal metabolism as a constant result of inactivity, the mental apathy due to lack of incentive, loss of will power, loss of hope, and the struggle against seemingly overpowering odds.

In the chronic orthopedic cases there are more problems for occupational therapy than in any other branch of reconstruction work. Not only has the long physical disability caused the mental change already spoken of, but one has to find occupation graded to the muscle power,

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Suprarenalin is recommended in Hay Fever in various forms. Herewith are suggestions made by men of authority.

One recommends using solutions of varying strengths from 1:10,000 to 1:1000 made up with normal salt solution. To sustain the relief to some extent, he suggests spraying over the constricted mucous membrane a 5 grain to the ounce solution of menthol in albolene, benzoinol or other light oil.

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   Heavy Magnesium Carbonate ..... 900 parts
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2. Suprarenalin ..... 1 part
   Zinc Oxide ..... 100 parts
   Bismuth subcarbonate ..... 400 parts
   Mix. Triturate well.
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   Zinc Stearate ..... 20 parts
   Zinc Oxide ..... 80 parts
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4. Suprarenalin ..... 1 part
   Bismuth subcarbonate ..... 300 parts
   Zinc Oxide ..... 300 parts
   Zinc Stearate ..... 200 parts
   Mix. Triturate well.

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Sodii boratis		30	or grs.	v–
Suprarenalin Sol. (1:1000)	4		or ʒ	i
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M. Sig. Use as a spray to the nose four or five times daily or oftener if needed.

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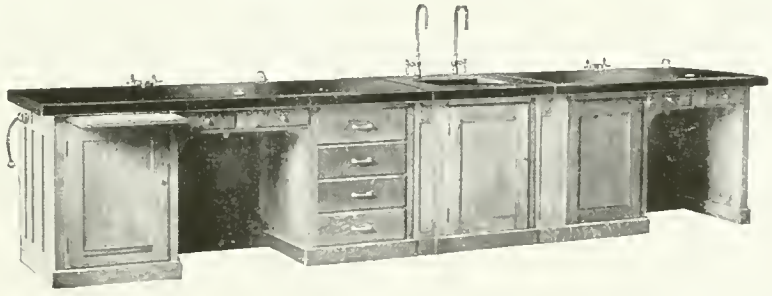

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to the nerve lesion, to the joint function, and of sufficient interest to start the normal mental reactions in the right paths. The particular case must be most carefully studied, not only mentally, but the physical injury that is present, must be known, and the probable degree of permanent disablement must be recognized. The final result in any orthopedic case must be definitely pictured in the physician's and therapy worker's mind before any attempt is made to give the patient work. As in most good work of any kind, high ideals, with recognition of our limitations, are essential. Otherwise failure is not only probable, but partial failure is assured.

Must Have Ultimate Goal

If you have no ultimate goal, how can you expect your hopeless chronic invalid to see the final prize to be worked for? *You* must give him the inspiration.

Again, if you set your hand to the task, never give up until your goal is reached. If you fail the chronic orthopedic patient you have done him the most irreparable harm; you have made him lose faith in you and his future.

With the arthritic patient you must have a knowledge of occupational therapy, and the patience of Job. You must never be at a loss in his presence.

I will not touch on the effect of work in the neurological clinic; better men than I have treated that subject. Most of my work has been done along the line of orthopedic occupational therapy, if the term may be permitted.

Each case in orthopedics presents different problems of muscle, nerve, joint, and bone lesions. Orthopedic occupations take in all parts of the body and must be adapted to produce better functional activity, but above all, to do no harm to the joints, muscles, and body. As Dr. Reginald Fitz used to tell his students, "Give anything you think best, but be sure to do no injury to the patient." Some form of pleasurable, useful, constructive work must be adapted to the individual patient's functional capacity. You will notice I say pleasurable. *Pleasure* is necessary because pleasure means better metabolism, and better metabolism means better circulation, and this means health. *Usefulness* appeals to the mind and gives hope of ultimate financial independence. It restores faith. *Constructive* means the gradual building up of muscles, increased motion of a joint, better function, more strength, less disability. The work chosen has to be capable of increase to the *n*th degree to meet all possible contingencies; capable of recessions which do not seem like losses; strategic retreats, not routs.

Let us consider the different structures with which orthopedic therapy work has to deal. These are muscles, joints, and nerves.

A muscle is the contractile fiber which by its power moves a bone on a joint. It is capable of short, sharp contractions in rhythmic waves. It has no sustained pull, but fatigues quickly unless rested. For example, the arm can be raised from the side an innumerable number of times with only slight fatigue, but it cannot be continuously held at right angles to the body for much more than a minute without pain and continued lameness. The heart is an excellent example; it beats and rests for a lifetime.

Adapt Occupation to Muscle Strength

Work for a muscle, then, must be active, with frequent periods of rest or change. This is accomplished by changing from the use of one group of muscles to another. A weak muscle tires quickly and the fatigue lasts long. If insufficiently rested, the muscle tone steadily decreases until exhausted. Therefore, occupation for the building of muscle tone must be so adapted to the muscle's strength, with sufficient time lapses between group action, to allow the weak muscle to recover. This is the only way to increase muscle strength. If we forget this, we injure the patient.

Joints are very delicate structures, having extraordinarily poor blood supply. They are hinges, covered with cartilage, enclosed in delicate capsules lubricated by serous fluid and moved by muscle action. Motion is necessary for their health. You have all read of the Indian fanatics who fix the arm in a position and hold it there until it becomes stiff and rigid. A joint has to be used for its own well-being, but it is highly susceptible to strain if over-used or improperly used. Consequently, great care must be exercised in choosing an occupation and in the practice of it at all times.

What are the symptoms and signs of over-use of a joint? They are pain, tenderness, swelling, and stiffness. In other words, inflammation. The important signs are swelling and continued pain. A damaged joint will always be painful, tender, and stiff after unaccustomed use, but it will not swell if not over-used, and the pain will subside quickly with rest. Consequently, one of the best guides is lasting pain and swelling. Soreness and transitory pain are not a contraindication to use, but pain and aching lasting for several hours, not ceasing with the stopping of work, show that inflammation has been produced and harm done.

Nerves are the connections between brain and muscle; without them muscles will not act and will degenerate. Often the nerve control is so damaged by injury or disease that muscle sense is lost. The patient does not know how to contract or use a muscle. If the nerve is still connected with the muscle, the control can be restored by exercise and practice. This is the object of occupational therapy in such a case. Repeated daily pleasurable lessons in control are better given by occupation than by gymnastics or exercise. Here is a great field for invention and ingenuity, in adaptation of work to an end.

Muscle Training Without Use of Joints

Let me illustrate the orthopedic principle of work by the history of a case. For five years, a young man, only twenty-three, had had an infectious arthritis which put him in the hospital, unable to sit up alone, to turn over, or to feed himself. The disease at first was so active that any motion was accompanied by groans. He was a civil engineer who had been in the field surveying, an active outdoor life. He had now been almost five years in bed. You can imagine the fearful, desperate, and hopeless man he was. At first nothing could be done with exercise of the hands; and here is a point of contact with the physiotherapy department. Muscle training can be given without use of points. Contraction and relaxation of muscles without motion was begun and did not produce pain; it was started in the trunk muscles first; abdominal exercises, etc. This had its effect on the gastro-intestinal tract, which lacked all tone. If joint exercise had been given at first, definite harm would have resulted; after the active disease was controlled, joint motion was beneficial.

In six months, with careful supervision, he was improving, the inflammation had subsided, and the painful hands and arms were capable of some work. This, however, had to be so mild as not to strain and stir up the joints and produce a relapse. The right hand would not close. The hands had no grip except between the forefinger and the thumb. The elbows moved about fifteen

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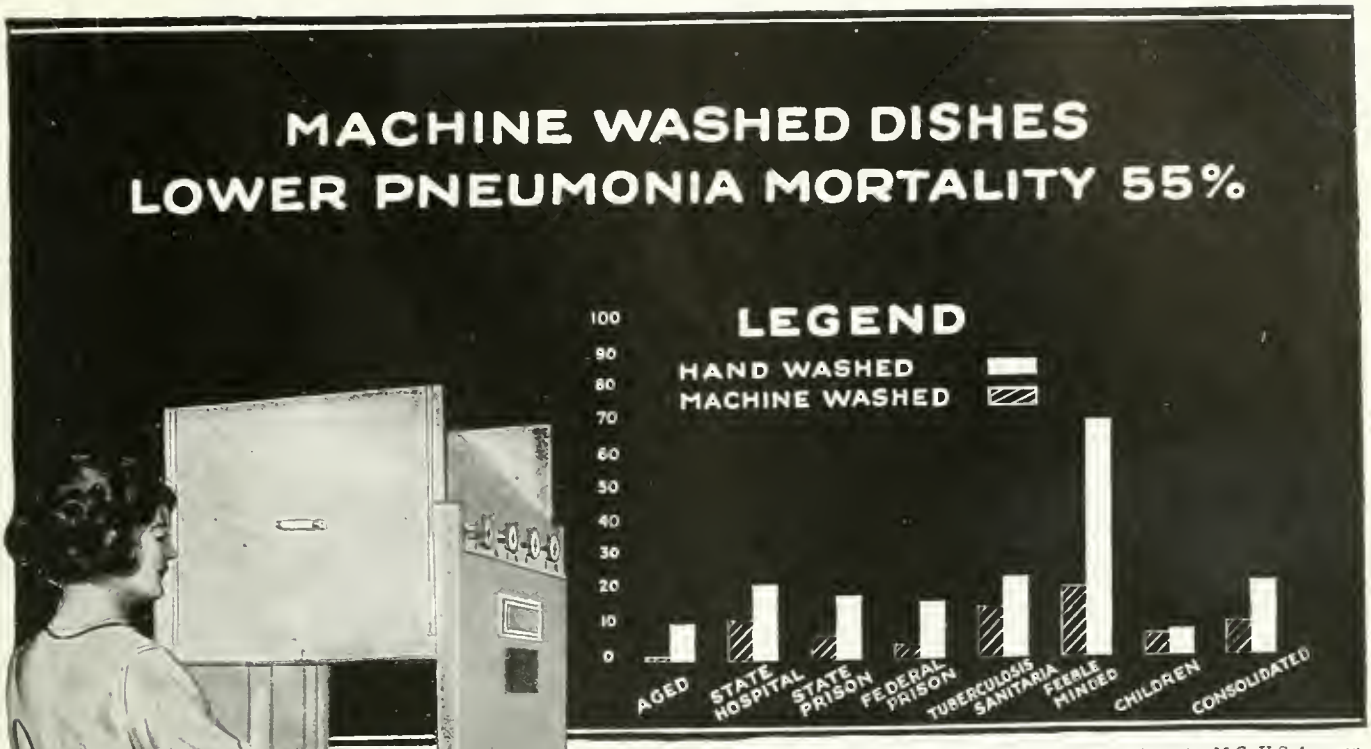
MACHINE WASHED DISHES LOWER PNEUMONIA MORTALITY 55%



This chart is from the article by Lt. Colonel James G. Cumming, M.C., U.S. Army, on "Influenza-pneumonia as influenced by dish washing in three hundred seventy public institutions," which recently appeared in the American Journal of Public Health.

What the Chart Proves

THE chart above is a summary of epidemical observations carried on in 370 institutions. The results of the investigation revealed that eating utensils were the major avenue of saliva-born disease distribution, and that it can be effectively blocked by the use of boiling water in the process of dish washing. Washing dishes with boiling water can only be accomplished by machine.

Of still greater importance is this statement:

"In those institutions where machine washed dishes were used, influenza-pneumonia mortality was 55% less than in those where hand-washed dishes were used."

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degrees, the shoulder was free in forward and back motion. He did not want to work. He hated knitting and rug making, but it was discovered he liked carving or whittling. Obviously, these were impossible. One day a light hand jig saw and a soft piece of wood with a simple design on it were brought in and the saw clamped to the small table he used for his meals. Nothing was said to him, but the nurse was told in his presence that if he wished to saw he could do so for five minutes. He tried it, but because he could not finish the work in that time, and because he was sore and lame, he did no more for two days. Then, after the first blank discouragement at the fact that five minutes was enough for him, he did a little work each day, until in a month, with the wood held under his left forearm, he would work for several hours. Best of all, he found he could feed himself.

Tried More Complicated Work

The designs offered during visits became too simple. He wrote to New York for patterns. In the next year he bought his own jig saw. He gradually got harder and better work and took to painting it, and during all this, his daily time had to be regulated by the joint reactions. There were set-backs, slight flare-ups, manipulations, but always the ideal was held up. The mental attitude was one of renewed hope, courage, ambition, fight. Small ideals, but yet ideals. Little battles won, until after a final manipulation he walked. Then ambition came with a rush. It was just as hard to keep him from doing harm with his spurts of work. He went home in two years, walking without crutches, carrying his box of jig saw tools under one arm, and the ideal of the foot jig saw in his head, almost able to dress himself, with joints which were steadily gaining in motion through work and use, and with the knowledge of success.

His further history is sad. He was well for a year, mowing the lawn, working at home, and was about to go to a lumber camp when the arthritis flared up, due to carelessness in his routine and overstepping his limit. We are again beginning to fight against heavier odds than ever, and a new occupation must be found, a new ideal created.

Such is one example. We have the same problems in infantile paralysis, hemiplegia, lateral sclerosis, spastic paralysis, fractures, nerve injuries, back cases. Occupation for the muscles is essential for their control and development, and is necessary for better coordination. In this connection looms are a means of general exercise for arms and legs, and there is far more pleasure than in exercises or gymnastics. I really believe, too, that a loom gives quicker results in coordination, because with it, action soon becomes subconscious. The regular, frequent repetition of a delicate exercise soon develops coordination and capacity to use a muscle correctly. The shuttle for the arms and the pedals for the feet are invaluable from an orthopedic standpoint in muscle training, muscle building, and nerve control. This form of work is the only one I know, except sawing, which fully exercises the elbow joints.

Loom Helps Infantile Paralysis

A young girl, twenty-two, was suddenly paralyzed from the waist down after an attack of infantile paralysis. The disability was almost complete. Both legs were entirely useless. After several years of trying this and that, some muscles had recovered their nerve supply, but were still very weak. It was suggested that she try weaving, simply because to use a loom would require her to lift and place her feet on the foot pedals at regular periods, at correct angles, at definite points. At first she had to lift each leg with both hands. In time she used only one hand, and lately she can just do it with her own leg muscles. The periods of work are painfully short, very discouraging, and she has to rest very often. Nevertheless, with the help of the loom standing at the foot of her bed, she can now walk across her room without her crutches, with the aid of canes, and this accomplishment, in spite of frequent falls, has made work for muscles which could not hold her eight months ago.

I think I have said enough about the problem of occupational therapy and chronic diseases as such. In this short space we can only touch the main basic principles which are fundamental, such as pleasure, usefulness, and, above all, in orthopedics, graded work for a definite physical purpose such as will promote normal function in disabled muscles, joints, and bones, without causing injury.

My experience with orthopedic patients in occupational therapy makes it necessary for me to draw your attention to several points of the utmost importance. With these chronic patients such as the arthritics, lateral sclerosis, poliomyelitis cases, one has to deal with a very much weakened vitality. It has been proved many times that in some cases who were not doing well with work, physically, it was the result of neglecting a very important part of the training.

Posture of Patient Very Important

By this I mean the actual method of doing the work. Much has been said about faulty posture, and to most of us it means the standing position of the body. The position of the body in bed, at the loom, at the jig saw, at the carpenter's bench, at the pottery wheel, is just as important. Invariably these patients have a lowered metabolism and weakened visceral function. If we allow them to sit, lie, or stand bent over so as to crowd these abdominal organs, or to produce back strain, we are not helping them by our work, but harming them. A thin, frail woman with no abdominal fat, has developed, through faulty metabolism, an atrophic arthritis. After rest in bed, building up, and regulation of metabolism, she has improved enough to do some weaving. She sits on a bench which is too high for the loom, and to use her shuttle she crumples in the middle. She compresses her lungs, sags her diaphragm, presses on her solar plexus, crowds her stomach and liver, and otherwise interferes with her main source of energy. She gets abnormally tired and pale with her work; her digestion becomes poor, until it is discovered that her work is not agreeing with her. At first the work is changed, but later the method of work is found to be the cause of the trouble. Different benches are tried, the height and angle of seat, the distance from the loom are all arranged so that she has to sit up straight while working. The change is at once apparent; there is less fatigue, less indigestion, a greater capacity to work, and increased benefit from the occupation, both physical and mental.

The same is true of positions in bed. Half reclining on a bed-rest crumples the abdomen and crowds the organs. The bent over position while standing at the work bench or the potter's wheel is injurious to backs. Stooping over the designing board is wrong. The chair used while sitting sewing or basket weaving must rest rather than fatigue the patient, by allowing the normal visceral functions to go on; otherwise it is harmful.

We think of this in the schools for the children. How many of us have the same consideration for the sick patient under our care? It is our fault if they do not improve.

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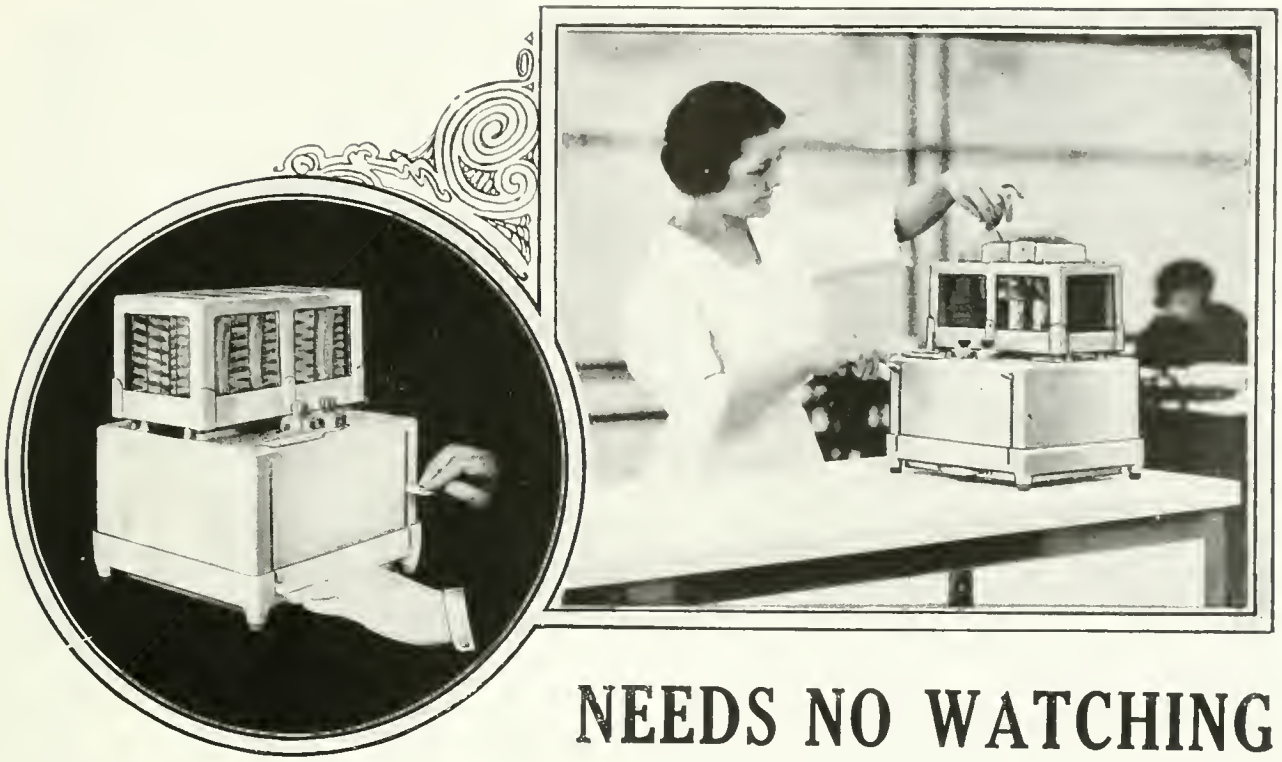

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Posture is so important that at Devereux Mansion no patient is allowed to begin any occupation until the bench, the chair, and the table are adjusted as nearly as possible to correct deformity, to prevent unnecessary fatigue, and to make it impossible to cramp a vital part of the human body. Arms and legs are worthless if the generators of normal body health, such as lungs, heart, stomach, liver, spleen, and intestines are interfered with. Never let your chronic invalids slump; they will never do you credit if you do, and the fault will be your own.

I beg you to carry this suggestion to your patients, to see that you are not blocking your own efforts by unconscious crippling of their sources of recovery and health. I firmly believe that medical care, physiotherapy, and occupational therapy are so closely united in the reconstruction of the chronic patient that the underlying principles must be sympathetically understood by each specialist in his individual line. Complete harmony and cooperation must be the rule and the knowledge of all combined.

For this reason I have brought to your attention the orthopedic aspects of our mutual problem; mine to secure normal function of body, joints, and muscles; yours to produce occupations and skill in teaching suitable for their up-building. We are necessary to each other. I urge you to study your patients mechanically so that you may do them no harm, but only good. They have enough to overcome without our adding a burden through our neglect of the normal functions of the body through faulty posture while working, improper exercise of joints, and wrong use of weakened muscles. Together we can accomplish seeming miracles.

MONTEFIORE OFFERS EXCEPTIONAL OPPORTUNITY

The Montefiore Home and Hospital of New York City offers a ten months' course in occupational therapy. The course is planned to meet the needs of two classes of students, (1) those who are skilled in one or more handicrafts and who need to supplement their knowledge with the theory and practice of hospital teaching, (2) those who have no knowledge of the crafts but who wish to take up practical hospital work as preliminary to the Teachers College (Columbia University) course in occupational therapy.

In the Teachers College certain credit will be given for the Montefiore work. It is possible that the hospital course will be shortened for those who are exceptionally skilled in the crafts, or who have exceptional personal qualifications.

Two scholarships will be offered in occupational therapy at Teachers College to persons having the highest standing in the training class at Montefiore.

A certificate from Montefiore will be granted to those who complete the course satisfactorily.

The subjects offered at the hospital are: physiology, anatomy, principles, methods and practice of hospital teaching, basketry, chair caning, weaving, knotting and netting, toymaking, plain and decorative needlework and simple garment construction.

As only ten students can be admitted, it is advisable that those interested should write at once for application blanks to the Director of Occupational Therapy, Montefiore Hospital, Gun Hill Road, Two Hundred and Tenth Street, New York City.

We learn wisdom from failure much more than from success. We often discover what will do by finding out what will not do; and probably he who never made a mistake never made a discovery.—Samuel Smiles.

THE ANNUAL MEETING OF THE N. S. P. O. T.

At the annual meeting of the Society next October, a remodeled constitution will be presented. The changes to become effective will require a two-thirds vote. The board of managers has given the matter much thought during the winter, and it is believed that the modifications suggested are all in the direction of simplification and effectiveness. The most important change to be considered is one which vests the entire government in a house of delegates, to be appointed from the various state societies, each state to have a representation according to the size of its membership. The house of delegates, if the new constitution is accepted, will appoint a board of managers from its own membership, and this board, during the year of office, will, with the president, attend to all the active business of the society. If the new constitution is accepted in its entirety the old cumbersome name of the Society will be changed to the American Occupational Therapy Association, certainly a much more desirable designation.

The Baltimore meeting promises to be the best in our history. Be sure to go if you can possibly manage it and try to enroll new members before October. Ask new members to send their names to Mr. Louis J. Haas, Bloomingdale Hospital, White Plains, N. Y., as soon as possible, so that they may be enrolled before the October meeting.

CALIFORNIA COMMISSION REPORTS WORK FOR 1920

The rehabilitation department of the California Industrial Accident Commission has dealt with 1,074 cases in the fiscal year just passed.

Physicians' and employers' reports of accidents are examined daily so that all cases that appear to have suffered an industrial handicap may be selected and early communication with them may be established. The special investigator, himself a handicapped man wearing two artificial hands, visits the San Francisco Hospitals in an effort to interest the men, under treatment, in re-education.

Of 538 cases personally uninvestigated, 334 have replied to communications, and 194 not responding were presumed to have readjusted themselves. Ten letters were returned unclaimed.

Two hundred and fifty-eight cases have been disposed of; some of them have returned to work; a few considered too old for re-education have sought light employment; some others have been paid lump sum settlements in order to enter a business of their own.

Of 278 follow-up cases, 103 were subject to re-education; twenty-nine returned to work but there was some doubt if all of them would be able to continue; twenty-five were too old for training but were eligible for placement in light work; thirty-eight desired a business of their own; thirty-five were not interested in re-education; and forty-eight were recent injuries.

The Commission had persuaded nineteen men to take training and to pay the necessary expenses out of lump sum settlements that were secured for them. Later in the year, when a fund became available for industrial accident cases, thirty-four men were placed in school and were continuing their training at the end of the year.

A placement bureau, in connection with the rehabilitation department is considered an essential not only for men who have taken up re-educational work and must be placed in wage-earning jobs, but also for those too old for training, and the temporarily disabled who would be benefited physically and mentally by being placed at light work.

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No. 875—Nurses' Operating Gowns—White Duretta Cloth—Per doz., now **$18.00.**

Patient's Bed Gowns

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DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR.

Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York

WHY SHOULD WE CHARGE ADMISSION FEES?*

BY JANET THORNTON, BOSTON DISPENSARY, BOSTON, MASS.

THE difficulty of obtaining accurate information from a large number of human beings and about any matter relating to human wants, is too familiar to require discussion here. It is also, I believe, readily understood that the difficulty is not lessened by the smallness of the money items involved in the change, namely, five, ten, fifteen, and twenty-five cents. I have endeavored to secure a basis of fact for statements made and to indicate, where facts were not available, what has been given as conjecture, and I feel sure that no finer procedure in the matter would be justified at the present time.

Why should admission fees be charged by dispensaries?

First, because public health institutions should be freed as thoroughly as possible from the "charity" or "dole" concept.

Second, because human nature values more highly what it must make an effort to acquire, hence patients are more earnest in their endeavor to profit by treatment they pay for.

Third, because the treatment required by the great majority of people is very little. Over 40 per cent of the patients pay but one visit, relatively few pay more than three.

Fourth, the small sums collected from many cases bulk large over the year, and make it possible to maintain better service. Then, too, such a source of income tends to place the whole institution in better relation to the community.

The adjustment of fees is a subject of great importance in dispensary management, yet it belongs rather in the class of secondary than primary importance. The main task in dispensary management today is the fuller utilization of the medical knowledge and skill offered by the staff of physicians. That it is of permanent importance to improve and expand medical knowledge and skill is generally granted. It does not, however, appear that boards of managers, the contributing and tax paying public, or physicians themselves, realize what inadequate use is at present being made in all dispensaries of the medical knowledge and skill presented. Careless and desultory clinic administration that fails to provide for the carrying out of prescribed treatment, is costly if no charge on the patient is made. A charge of $1.00 or even $5.00 a visit may be inexpensive for very low incomes, if the clinic administration is so perfected that the full nature of the patients' medical problem—physical, mental, personal, environmental—can be analyzed, and full thought taken for the discovery and application of practical remedies for his medical problem.

Certain patients or their parents when asked directly how they felt about paying more for treatment, replied in general that they felt the fees were still very small, that they desired to pay as much as they could for the service, and that they understood how the rise in prices of nearly all things would require increase in the dispensary's income. Not one complaint was made to the cashier or any other employee in the dispensary even in the first days of the change, nor has any been made since.

Such mute acquiescence does, however, not truly tell whether the increase which gives the dispensary $600.00 to $700.00 additional income each month is a hardship to those paying for it; for,

(1) People are now used to rising prices,

(2) Other hospitals have for some time been charging higher prices than the Boston Dispensary (Massachusetts General Hospital, Peter Bent Brigham, Children's, etc).

(3) All out-patient and dispensary rates for treatment as compared with rates in private medical practice are well known to be very low (from one-third to one-sixteenth).

It is necessary, therefore, to seek other evidence than that obtained by questioning patients in regard to their impressions and reactions in the matter.

Evidence Afforded by Statistics

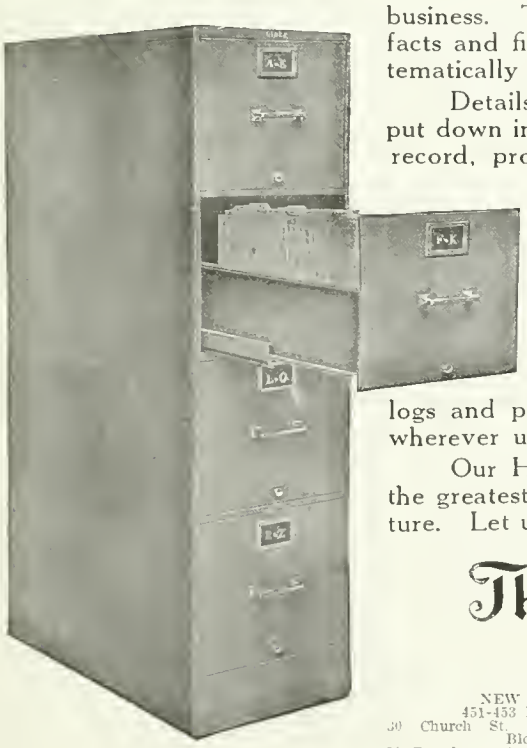
More patients attended during the autumn of 1920 (after the increase in admission fees), than during any previous autumn in the dispensary's history. More free treatments were given to those unable to pay the fees, nevertheless, more income from fees was realized than

*During the past decade or so, the Boston Dispensary, like many other clinics throughout the country, established and developed a system of charging admission fees to dispensary patients, remitting these fees in case of inability to pay. At first a fee of ten cents was charged in some clinics only; then for some years fees of twenty-five cents for the first visit and ten cents for later visits, for adults, and ten cents for all visits for children, with small extra fees for medicine and special treatments. In 1913 and following, evening pay clinics were developed, which charged a fifty-cent fee per visit, or in some instances, one dollar for the first visit and fifty cents thereafter. In the autumn of 1920, after considerable discussion, the fee rates were increased, in the morning clinics to twenty-five cents for all visits, twenty cents for adult returns, and fifteen cents for all children, and in the evening clinics to seventy-five cents instead of fifty cents.

The board of managers of the Boston Dispensary felt considerable doubt as to whether the increase in fees would or would not work hardship on the patients, and limit the service rendered by the institution. Consequently they asked Miss Janet Thornton, who has been for years a member of the social service department of the dispensary, and was for a period in charge of the admission of patients and of the social aspects of clinic administration, to make a special study of this matter.

Adv. page 50

Proper Records, Properly Kept



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during any previous period. Hence, it might perhaps seem safe to conclude without going further, that the increase in admission charges beginning September, 1920, had not placed too heavy a burden on the patients, and that the addition of six hundred to seven hundred dollars a month to the dispensary's revenues was clear benefit. In the main, the conclusions appear to be warranted; yet, the whole matter of rating and collecting fees in a dispensary is so intimately involved with fundamental purposes and policies of the institution that more careful inquiry and interpretation is demanded. From the basis of facts secured through inquiry, if properly interpreted, it should be possible to determine (with greater accuracy and assurance), future policy regarding this aspect of dispensary management; and careful inquiry very soon shows the problem to be a complex one.

A study of statistics of attendance at the Boston Dispensary shows that there has been a very rapid and continuous growth during the past twenty years, these visits at three ten-year intervals being as follows:

1900	80,044
1910	101,461
1920	152,682

On comparing the seven years from 1914 to 1920, however, the attendance is found to fluctuate somewhat, dropping considerably during the war period, 1917-1918, and rising rapidly during 1919-1920. It may be added that the drop in the two years mentioned was general, not only in the Boston Dispensary but elsewhere in the country. The fluctuations at the Boston Dispensary, in a word, are apparently less due to changes in fees than to general conditions.

Working to finer detail, and comparing the attendance in the morning clinics and the evening pay clinics respectively, for the autumn quarters of the past six years, we find that in general the tendency of the morning figures is to decrease and of the evening figures, to increase.

Even more significant, perhaps, has been the marked rise in the proportion of the number of visits to the number of new patients in the past two years. Finally, a decrease both in new patients and in visits has occurred in previous periods where no increase in fees was made; in fact, the lowest numbers which have recently occurred were in 1918 when there was general prosperity in the community and when the ten cent, twenty-five cent, fifty cent, etc., charges were far smaller items in relation to wage rates than they had been at any previous time.

It appears, therefore, that a change in fees is but one of numerous factors that enlarge or reduce the use made by the community of the dispensary. Army drafts, war activities, war prosperity, war adversity have played their parts in the past seven years; as well as venereal disease campaigns, Children's Year, Life Extension propaganda, and other public health movements that have educated people in health matters.

But considering the large groups of workers whom we know at the present time to be totally or partially unemployed, and the prevalence of financial distress among workers generally, the question may be asked whether persons needing medical care have been deterred from obtaining it at the Boston Dispensary because of charges for this service beyond their means? Who shall answer this question? I believe no one can give a clear cut "yes" or "no." It can be unqualifiedly asserted that no one applying was ever turned away because of inability to pay, and that persistent and searching endeavor was made to discover and assist those needing free treatment even to the extent in many cases, of following them to their homes and supplying car fare for the return trip to their clinic. Yet, on the other hand, it is now beyond doubt that September, 1920, was an unfavorable season for raising admission fees at the Boston Dispensary. Economic distress among our patients and internal readjustments within our walls are circumstances that have of necessity made the change difficult. They have combined to add severe strain, already heavy by reason of the large increase in clinic attendance, to the social service workers, especially at the admission desk and in the clinics.

In the evening pay clinics, fifty-five fewer new admissions were made, and 2,095 fewer visits in the autumn quarter of 1920 as compared with the corresponding period in 1919. In what degree was this due to increasing the fees from fifty cents to seventy-five cents for return visits. Two of the six evening clinics increased both in new admissions and in visits, and in three of the remaining four clinics, the reductions were very slight, and were largely compensated for by increases in the corresponding morning clinics. When patients were found to be out of work or in financial difficulties, the social workers in the clinics consistently transferred them from the evening pay clinics to the morning sessions.

> The striking increase in return visits during the past two years is also to a large extent evidence of better service, for it cannot be too often reiterated that no factor in clinic management is more important than the holding of patients until diagnosis and treatment can be brought to completion. Medical knowledge and skill is of little avail to the casual patient. In addition, the more careful attention to the financial condition of the patient for the purpose of adjusting dispensary charges, has resulted in benefits to him far greater than the mere saving of small sums for food and other necessities. A deeper and more complete understanding of his whole problem has resulted, and therefrom has come the power to render him fuller and more lasting relief.

In the genito-urinary clinic, the morning clinic showed a gain of 441 visits during the quarter, but the evening clinic, a loss of 2,105 visits. One may conjecture several plausible explanations for the drop in this clinic. For instance, there has been a general slackening of interest in venereal disease since demobilization was accomplished, and certainly fewer patients are sent to the dispensary by the courts for venereal disease treatment. Such explanations have probably some long range value, but it seems possible to find less conjectural and more immediate causes for the marked drop in the attendance in the Boston Dispensary genito-urinary clinic after September 15, 1920. I have myself no hesitation in ascribing most of the decline to two interrelated factors, the increase in fees, especially the seventy-five cent charge at night, and the temporary disturbance of the social service in the clinic. It is very probable that the evening pay clinic would have lost patients during the present business depression and unemployment had there been no increase in the admission fee; but the loss might have been largely compensated for by thoughtful and vigorous social work.

Do we know the incomes and the needs of the people from whom the Boston Dispensary accepts fees?

In 1912, the Boston Dispensary stationed a social worker at its admission desk to ascertain knowledge of

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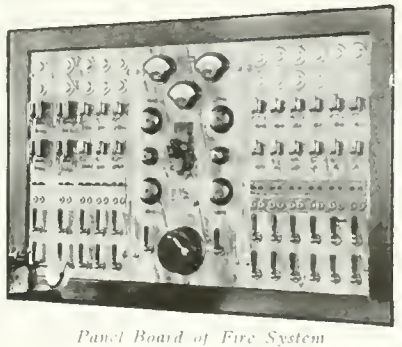

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the needs and resources of its clientele. Gradually social workers have been added to the staffs of clinics, and from these strategic points, the clinic physicians, as it were, have been able to supplement the notes from the admission desk, with fuller and more accurate knowledge of the patient's condition, medical and social. A somewhat different type of dispensary organization has resulted. All patients are scrutinized from the social as well as medical standpoint, and in planning for the relief of the medical disturbance, the personal and social life of the patient, his family and working relationships, his personal habits and point of view are all taken into the reckoning.

Two-Thirds of Clientele Have Insufficient Incomes

Considerable knowledge has been ascertained concerning the incomes of our patients as well as the number of persons living on the incomes. From time to time, this knowledge has been classified and formulated in statistical studies. All the studies have shown that fully two-thirds of the Dispensary's clientele have incomes below the minimum standard required for health and decency. A tabulation of five hundred cases from morning clinics in November, 1920, gave the following results:

Dependent on charity	3.4%
Dependent on relatives	5.8%
Unemployed	17.6%
Incomes lower than minimum standards for health and decency	66%
Incomes above minimum standards for health and decency	7%
	99.8%

That is, 93 per cent may be described as either in or very close to the danger zone of economic insufficiency. For more concrete illustrations, I quote the following: Three hundred and fifty-one out of 500 cases consisted of families (father, mother and children), and more than half of these families had less than $1,300 to subsist on in the year 1920. Only thirty-nine families, 11 per cent, had incomes over $1,800 during 1920.

Similar figures were obtained in 1917, 1915, etc., if allowance is made for changes in the value of money. In 1915, for example, 77 per cent of the Boston Dispensary families were living on $800 or less per annum, which, even in 1915 when the purchasing power of money was much greater, was well below the so-called American standard.

Such quotations (and many other detailed illustrations could be adduced), illustrate sufficiently the point I aim to make, namely, that even small charges (ten, fifteen, twenty-five, fifty cents, etc.), are a considerable tax on the slender resources of patients, especially families, seeking dispensary care.

Remission of Fees

Patients unable to pay the regular dispensary fees have these remitted in whole or in part. In the autumn quarter of 1917 a careful record showed that out of a total of 7,631 different individuals treated, 1,250 received one or more fee remissions, this being a percentage of 16.3 of the total number of individual patients. Of these 1,250, only a few (ten to twelve per cent), received more than one dollar's worth of remission, and fifty per cent received thirty cent's worth or less.

From families living in 1917 on $12.50 to $14.00 per week,	89% paid
From families living in 1917 on 14.50 to 16.00 per week,	94% paid
From families living in 1917 on 16.50 to 18.00 per week,	94% paid
From families living in 1917 on 18.50 to 20.00 per week,	95.5% paid
From families living in 1917 on more than $20.00 per week,	95.6% paid

The reasons given for not paying the regular dispensary's charges are much the same from year to year, widows with dependent children, families of deserting or nonsupporting fathers, families of permanently disabled fathers, sickness and injury causing temporary inability to earn, total or partial unemployment, aged and infirm persons not members of family groups, inadequate income either because of inferior earning capacity or because of large family.

The evidence as I find it, suggests that many patients are (and have been for the past eight years), paying dispensary fees who for the best interest of their own and of the community's health should not be doing so. In 1917 I felt very strongly that this was the case, and after the three months study of the subject referred to above, it was decided by the dispensary administration to reinforce social service in clinics, and make greater efforts to adjust the amount charged to the means of the patient.

The increase in number and proportion of free passes is some measure of the improvement in service to patients; 9,179 free admissions were given in the fourth quarter of 1920, as compared to 6,447 in the same period of 1919.

> We are in a transition state in dispensary work, passing from the charitable and teaching foundation period into the public health period, from the individualistic practice of medicine into the cooperative group system. The latter is far more costly than the former, because more complete, and must grow even more costly as the demands of medical research and equipment become greater. Meanwhile, preventive medicine requires the maintenance of a high standard of living. Vitality must be increased and conserved, and this means food in plenty, rest, recreation, opportunity in work for self-development and expression. Yet for so many people these things, though they seem not too much to expect from life, and though they exist in abundance enough for us all, are not to be had. Lacking them in any large measure, no amount of "doctoring" will bring results.

The striking increase in return visits during the past two years is also to a large extent evidence of better service, for it cannot be too often reiterated that no factor in clinic management is more important than the holding of patients until diagnosis and treatment can be brought to completion. Medical knowledge and skill is of little avail to the casual patient. In addition, the more careful attention to the financial condition of the patient for the purpose of adjusting dispensary charges, has resulted in benefits to him far greater than the mere saving of small sums for food and other necessities. A deeper and more complete understanding of his whole problem has resulted, and therefrom has come the power to render him fuller and more lasting relief.

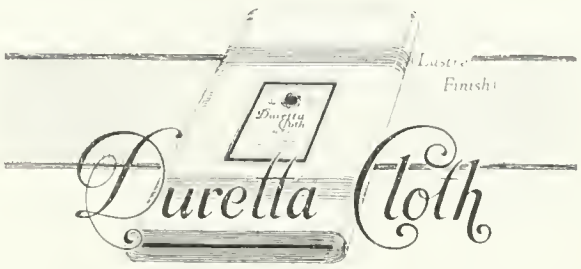
Now, if it be true as I have stated, that only a small number of Boston Dispensary patients have means sufficient to maintain health and a decent standard of living, and many live in constant poverty, how can one justify the collection of any fees for medical care? Four grounds appeal to me as reasonable justification for the system of charging for dispensary treatment.

First, that public health institutions should be freed as thoroughly as may be, from the "charity" or "dole" concept, in the minds of both patients and doctors. The institution paying the doctors for service and charging the patients to the limit of their ability to pay, is doing more than anything else to erase an outworn and obstructive, though still amiable, notion of public health as philanthropy.

Adv. page 54

Uniforms which are Pleasing to the Eye and Pocketbook.

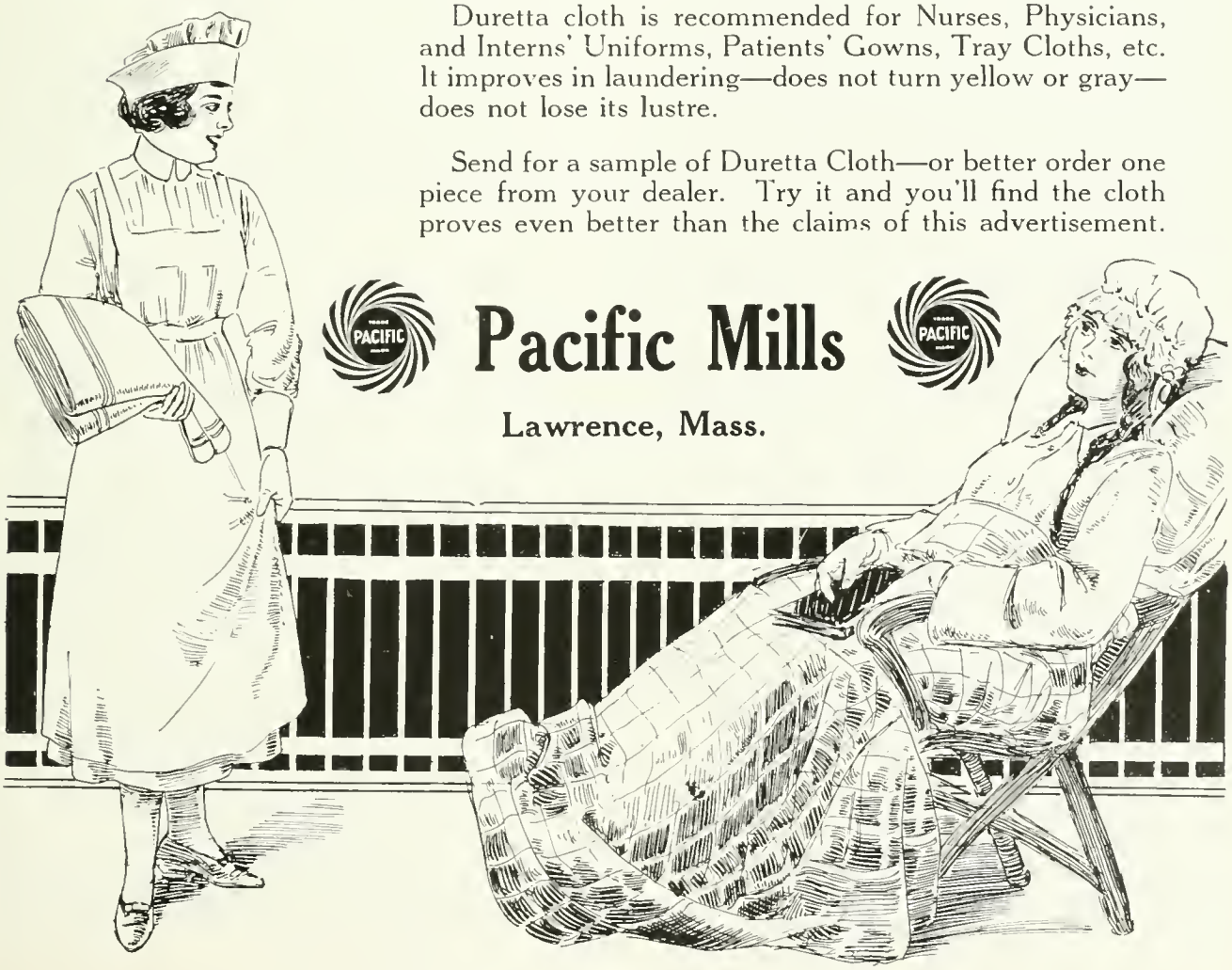
Along with the trend toward pleasant locations, attractive interiors, and a cheerful atmosphere in hospital operation, comes Duretta Cloth which transforms the hospital uniform into a pleasing well-fitting nice looking garment, rather than a starched, stiff and rough suggestion of a harsh institution.



Sales of Duretta Cloth to hospitals have grown at an amazing pace since it was first placed on the market. It is a white cotton twill, soft and draping, with a lustrous appearance which never leaves it until worn out. It lasts so long that it proves an economical cloth as well as one with an improved appearance.

Duretta cloth is recommended for Nurses, Physicians, and Interns' Uniforms, Patients' Gowns, Tray Cloths, etc. It improves in laundering—does not turn yellow or gray—does not lose its lustre.

Send for a sample of Duretta Cloth—or better order one piece from your dealer. Try it and you'll find the cloth proves even better than the claims of this advertisement.



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Second, human nature values more highly what it must make an effort to acquire, hence, patients are generally more serious and earnest in their endeavor to profit by treatment they pay for, and, having made the effort to acquire the treatment by paying something for it, their feeling of self esteem is maintained.

Third, even more vital and cogent, the treatment required by the great majority of people is very little, the treatment sought is even less. Over 40 per cent of the patients coming to the Boston Dispensary pay but one visit, relatively few pay more than three. Even the most expensive dispensary treatment given, that for gonorrhea, syphilis, and orthopedic adjustments requiring braces, etc., will seldom exceed $25.00 to $30.00 at morning clinic rates.

This argument is substantiated by study of actual cases, detailed in the appendix. It is apparent that to the average dispensary family, spending only a few dollars a year for the needed medical attention, such sums paid out gradually over a twelve months' period cannot very noticeably affect the general standard of living.

Fourth, on the other hand, the small sums collected from many cases bulk large over the year, some $68,000 in 1920, and make it possible to maintain better service. (Such a source of income also tends to place the whole institution in better relation to the community.)

Yet, when all is said, it is bare honesty to recognize that we are temporizing in the matter. We are in a transition state in dispensary work, passing from the charitable and teaching foundation period into the public health period, from the individualistic practice of medicine into the cooperative group system. The latter is far more costly than the former, because more complete, and must grow more costly as the demands of medical research and equipment become greater. Meanwhile, preventive medicine requires the maintenance of a high standard of living. Vitality must be increased and conserved, and this means food in plenty, rest, recreation, opportunity in work for self-development and expression. Yet for so many people these things, though they seem not too much to expect of life, and though they exist in abundance enough for all, are not to be had. Lacking them in any large measure, no amount of "doctoring" will bring results.

Appendix

ILLUSTRATIVE CASES

Medical Service for One-Year Period.

C FAMILY. Father, mother, two children. Arrested tuberculosis.

Mother: 4 clinics, 17 visits at 10c	$ 1.70	
Prescriptions	1.30	
Glasses	10.00	
		$16.00
Girl, 12 years: 2 clinics, 9 visits	.90	
Prescriptions	1.85	
		2.75
Girl, 10 years: Tuberculous hip, spine, and orthopedic surgery in previous years—		
5 clinics, 30 visits	3.00	
X-ray	1.00	
Prescriptions	9.65	
		13.65
Total expense to family for medical care at Boston Dispensary during year		$32.40

L FAMILY. Father, mother, five children.

Father: Heart disease, from which he died about two months after coming to the Dispensary. One visit by the clinic physician to his home, some nursing service, and sick room comforts not included. (Free.)		
2 clinics, 4 visits	$ 0.55	
Prescriptions	1.45	
		$ 2.00
Mother: Much pelvic disturbance, also eye, throat, and orthopedic, etc., defects. Cost of operation for pelvic condition performed in another hospital not included. (Free patient.)		
7 clinics, 33 visits	$ 3.30	
X-rays	3.00	
Glasses	2.50	
Prescriptions	5.75	
		$14.55
Son, 16 years: Working and well. Medical examination for precaution—		
1 clinic	$ 0.25	
		.25
Daughter, 15 years: Working and well. Medical examination for precaution—		
1 clinic	$ 0.25	
		.25
Small daughter: 3 clinics, 5 visits	$ 0.50	
Throat operation	4.00	
		4.50
Small daughter: 2 clinics, 9 visits	$ 0.90	
Prescriptions	3.05	
		3.95
Total cost to family for medical care during one year		$25.50

The treatment of syphilis and gonorrhea is the most costly to the patient of any given in out-patient work, because of the frequency and long duration of the treatment necessary. The following cases, therefore, give an idea of the extreme charges that the Dispensary patients can be asked to bear:

Mr. I—Treatment During 1920—

Chronic gonorrhea and syphilis (early). 2 clinics, 107 visits, 11 arsaphenamine injections, laboratory tests, prescriptions—

Cost to patient at morning prices:	
Old rate	$ 42.50
New rate	49.65
Cost to patient at evening prices:	
Old rate	78.50
New rate	105.25

Mr. V—Treatment During 1920—

Neurosyphilis (losing eyesight). Rectal condition. Hemorrhoids. 3 clinics, 95 visits, 42 arsaphenamine injections, laboratory tests, prescriptions—

Cost to patient at morning prices:	
Old rate	$ 57.45
New rate	66.95
Cost to patient at evening prices:	
Old rate	95.45
New rate	119.20

K FAMILY—Treatment During 1920—

Syphilitic family (father, mother, and five children) all treated adequately during 1920. 87 visits, 38 arsaphenamine injections, 21 prescriptions, laboratory tests, x-ray, eye glasses for one member

Cost at morning visit rates @ 10c	$ 77.05
@ 25c	$ 85.75

These are extreme cases and the majority of patients pay much less. A high proportion, certainly a third of the cases, make but one visit. Few surgical clinic cases cost over $1.00, and half come within $0.50. The enumeration of several actual cases of a serious character, completely and satisfactorily handled in surgical and medical clinics, will give a picture of the more nearly average condition.

Chronic paronychia, finger, 2 months duration—	
10 visits at 10c a visit, operation under gas	$1.50
Pyelitis, child, 1 year duration—	
15 visits at 10c a visit	$1.50
Drugs	1.80
	$3.30
Pulmonary tuberculosis, 20 months duration—	
22 visits at 10c a visit	$2.20
Drugs	2.00
	$4.20

IMPORTANT COMMITTEES TO REPORT AT CONVENTION

The committee on Hospital clinical and administrative forms and record keeping, which has been actively at work for several months past under the chairmanship of Dr. H. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, will, it is understood, submit its report at the September meeting of the American Hospital Association.

The committee, which is making a study of hospital flooring under the chairmanship of Dr. Frank E. Chapman, superintendent, Mount Sinai Hospital, Cleveland, Ohio, will also submit a report at the West Baden meeting. This committee is at work collecting facts regarding different types of floors used in hospitals, as well as authoritative opinions as to their desirability and usefulness in the various departments in the hospital.

Physiological experiment on animals is justifiable for real investigation, but not for mere damnable and detestable curiosity.—Darwin.

Adv. page 56

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XVII *September 1921* No. 3

ISOLATION OR PROGRESS?

By A. R. WARNER, M.D., Executive Secretary, American Hospital Association, Chicago, Ill.

IS IT isolation or progress with you? It cannot be both. There are situations so opposed that they cannot exist together, and these are of such a character. This applies with particular and unfortunate force to hospitals and hospital workers. The best, the kindest, and the highest of motives and purposes cannot bring exemption from any of the written or unwritten laws of humanity. All remains subject to every human force and tendency.

On which side are you and your hospital? No one can claim a brain power equal to that of all the rest of the field combined. Help from others can therefore be obtained by all. Are you getting as much as is possible?

Bettering Hospitals' Service

The American Hospital Association exists to better the service rendered by hospitals. The factors in such service are: 1. Properly trained and competent professional and non-professional attendants for the patients. 2. Availability of essential laboratory and other equipment. 3. Proper operating (general administration—not merely surgical) policies and technique. Any and all of these factors can exist in a small as well as in a large hospital, but none of them come without effort, or with size, or years. Good hospital service depends upon brains and effort, brains to develop, organize, and direct the required professional skill and constant effort expended to keep all the hospital working efficiently, and to keep informed at all times as to what efficient work is.

A proportional amount of brains and effort should come from the trustees and the superintendent, and it is unfortunate when the medical staff has to do everyone else's work as well as its own.

In other words, the quality of hospital service rendered does not depend on the size of the hospital, and it depends on the location of the hospital in reference to centers of population only as that affects the professional skill obtainable in the medical staff and other personnel. The largest contributors to progress are not always the largest hospitals.

The problem of the "small hospital" is not synonymous with the problem of "poor hospital service." It is synonymous with that of the isolated hospital of any size. The small or isolated hospital problem is the problem of forming the lines of communication to six thousand hospitals scattered throughout the country away from the large centers of population, that each may know of the other's policies, that each may get the help needed on its special problem when it is needed.

It is the problem of working out the routine by which the results of the planned or unintentional experiments and researches of the university or other hospitals can be made clear to all of these six thousand isolated hospitals, and also the problem of stating the results in principles applicable to hospitals of all sizes and kinds.

Dissatisfied Hospitals Progressing Faster

But lines of communication are without usefulness when only one receiver is down. The message is wasted. How can the isolation be broken?

The problem of "poor hospital service" seems to have some connection with self-satisfaction and contentment within the institution over its work. At any rate the hospitals dissatisfied with their work and trying to make it better seem to be the ones giving the best service, professional and otherwise, and the ones most satisfied with their ways of working seem to be the ones giving the worst.

Handicaps recognized as serious within the institution do not exist long. When so recognized someone always does something about it. There is no gain in having everybody outside the institution see the defect. Often perspective makes the defect stand out the plainer. Someone within the institution must at times get far enough away to let the details blend into a background for the essentials and to see their institution as others see it, to look at it with the others and to talk about it with the others.

The cost of equipment essential to the proper protection of patients or good service seems always to be forthcoming to even small hospitals as soon as it is declared to be essential by someone considered capable of distinguishing between an essential and a fad.

Experience is a great teacher, but its greatness is directly proportional to the amount of experience behind the teaching, whether it is a single experience or the combined experience of many working with the same problems. Personal experience teaches only when you have it, not when you need it or want it. It helps, but it is never enough to keep one in the front line of hospital work. You must be able to use the experience of others in the problems new to you.

Don't Depend Entirely on Publications

You must know figures, facts, and the composite results of many experiences. You must know the results of the experiments of others. You must know how others are thinking. You must have the opportunity to talk over with others your problems as you see them and as you are dealing with them. You should hesitate always to depend on published articles and general advice on the subject. They cannot take into consideration the local or special conditions and these may be important.

The hospital journals will sooner or later bring much advice and guidance to you, but seldom just when you need it. The need is to have your present problems answered now, and those to come answered as they develop. If by chance any have been answered by reading the experience of others beforehand, the problem does not develop as a problem. Reading is never wasted effort. Hospital journals break in on your hospital isolation exactly as newspapers break in on family or community life.

But picture for yourself that family or community in which the only contact with the rest of the world is through newspapers. That picture can properly be applied to the hospital or hospital worker whose only contact with the rest of the hospital world is through the journals. Is this not so?

There are several ways in which personal contact with the rest of the hospital world can be developed, and they all count. But the most concentrated application is the annual conference week of the American Hospital Association. All are there for the same purpose. It is a week devoted by all to the giving and the getting of new ideas and a knowledge of what the others are doing.

The program of the annual conference this year (West Baden, Ind., September 12-16, 1921) has been planned with just this, and all this, in mind.

There are but a few formal papers and all are on the program because they contain something of value. Only those who had a special, worth while, up-to-date story to tell were given a place. No one is there in recognition of any other facts or factor.

To Be Six General Round Tables

There will be six round tables for the consideration of everyone's problems, grouped as follows: (1) General Administration; (2) Department Work, (3) Out-Patient Work; (4) Construction; (5) Purchasing; (6) What Constitutes Good Service to the Patient. You are urged to send in your questions in advance, that care may be taken to see that the right persons are present to answer these questions, and to give them time to formulate their answers. A written question sent in any time now will be taken up and discussed in these round tables.

There will be reports of five special committees, which will standardize hospital policies in these five matters. There will be free discussion of each.

The superintendent and trustees of hospitals should attend the annual conference of the American Hospital Association this year for the following reasons—making each reason a purpose:

1. To help the Association find an effective way to "get over" to the isolated and non-experimental hospitals the results of the experimental and test work undertaken by university and other hospitals. This will come only through *talking* (not writing) with you.

2. To develop the connection between the Association and the hospitals such as will make possible the transfer of data and information and the use of desired consultations not only at the conference but *throughout the year*.

3. To keep themselves and their hospitals informed, out of the rut, up to date, and *efficient* notwithstanding size, handicaps, or location.

4. To find out the real *facts* about the problems that are troubling them now.

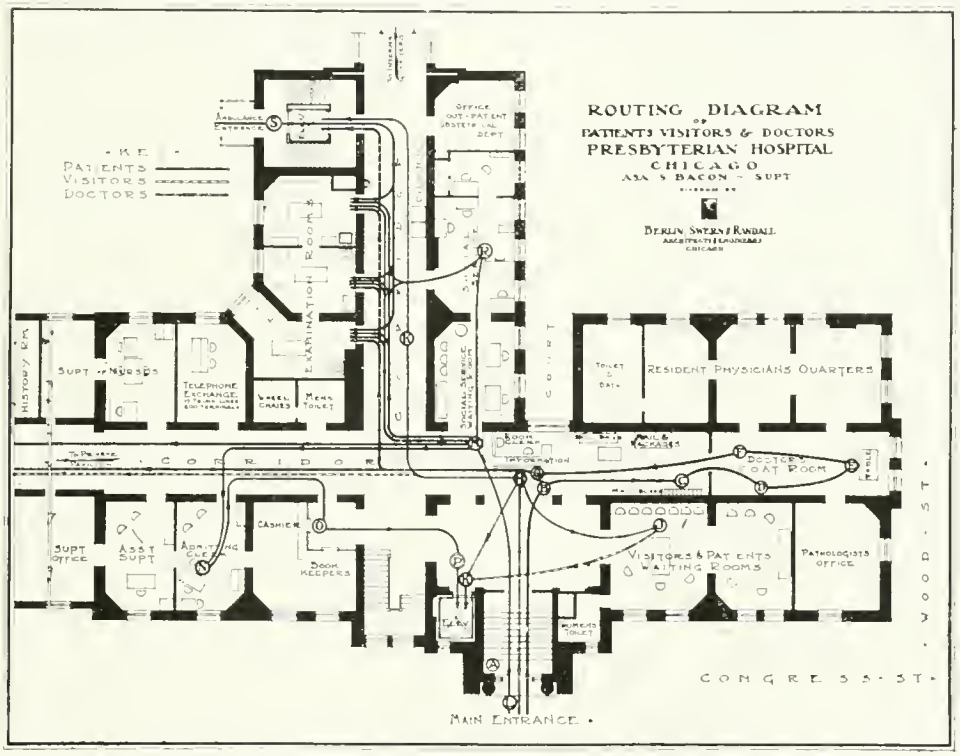
Will you come?

ROUTING OF PATIENTS, DOCTORS AND VISITORS

By ASA S. BACON, Superintendent, the Presbyterian Hospital, Chicago, Ill.

IN BUILDING new hospitals and remodeling old ones the question of routing doctors, patients, and visitors has not received the proper consideration, and serious mistakes have been made. The matter is of so much importance that the editor of THE MODERN HOSPITAL asked me to give a description of how it is done at the Presbyterian. While I do not consider the scheme outlined a perfect one (for I had to work it out within a building already constructed), it has proved very satisfactory during a period of many years, and I trust it will be helpful to other institutions. In order that you may get a better picture of our work, I will tell you something of our hospital and its organization as a preliminary to the routing information.

We have no free wards, although ours is a teaching hospital, so our pay and free patients are mixed. When a charity patient leaves the administration floor, no one except the attending physician knows he is a charity patient unless he tells it himself, therefore he receives the same care and is treated in the same manner as a pay patient. We have a private pavilion of ninety-five



Routing of Patients, Visitors and Doctors in Presbyterian Hospital, Chicago.

DOCTORS

A—Door man reports by telephone to telephone operator that Dr. Brown is coming in.
B—Information clerk reports to telephone operator that Dr. Brown is coming in. (Making a double check.)
C—Doctor secures mail.
D—Doctor hangs up coat and hat.
E—Doctor looks over mail and messages. (Telephone available.)
F—Doctor meets intern who has been previously called by telephone operator.
G—Information clerk informs doctor of waiting patients and other calls which are disposed of, and he then proceeds to various floors. Going out the doctor reverses the operation—G, D, B and A.

VISITORS

H—Visitors enter and proceed to information clerk, where they are given Form No. 1 and are checked in patients' doorbook.
J—Visitors' waiting room.
K—Visitors proceed to various floors.

PATIENTS READY FOR ADMISSION

L—Doorman meets patients and assists them from taxi cab with baggage, conducting them to room clerk.
M—Room clerk questions patient, securing name, fills out Form No. 2, rings for bell boy and gives form to him.
N—Bell boy takes patient to admitting clerk, where Forms 3, 4, 5, 6 and 7 are filled out, No. 7 being given to the patient, and 5 and 6 to bell boy.
O—Bell boy takes patient to cashier, where valuables are deposited for safe keeping and receipt is given (Form No. 8), patient also makes payment on room and board and receives receipt (Form No. 9).
P—Bell boy conducts patient to nurses' station indicated.

PATIENTS TO BE EXAMINED

L—Same as above.
M—Patients to be examined are given Form No. 10 by room clerk and conducted by bell boy to examining room. After examination, patient returns to room clerk with Form No. 10 filled out. Form No. 2 is then given to bell boy.
N—O—P—Same as above.

CHARITY PATIENTS

L—Same as above.
M—Charity patients or those that state they cannot meet required rates of hospital when told by room clerk of the available facilities, are given Form No. 11.
R—Bell boy conducts patients to social service department, where arrangements are made for care of the patients. Social service refers patients to examining room or back to room clerk, if examinations have been made previously.
N—O—P—Same as above.

AMBULANCE PATIENTS

S—Patients enter hospital and are taken directly to examining rooms, where Form No. 10 is made out by nurse, who obtains information as to available rooms from room clerk, and patient is sent directly to bed assigned, or operating suite in case of emergency. Admitting clerk secures information for Forms 3, 4, 5, 6 and 7 from accompanying friends or patients at bedside later.

rooms, and thirty-five inexpensive rooms scattered throughout our two ward buildings. Together with these, we have fourteen semi-private rooms and sixteen three- and four-bed wards; the balance of 210 beds is divided into large wards of from eight to twelve beds each. The various floors are reached by four passenger elevators, three of which run from basement to sun parlor on the roof, the highest being eight stories.

The distance from the main entrance door to the information desk is thirty-seven feet; from the information desk to the examining room is thirty-five feet, and from the examining room to the admitting clerk's office is forty-three feet. From admitting clerk's office to the elevator, passing the cashier's window, is forty-five feet. Thus you will see that the distance traveled is very small in comparison to the size of the building and the large number of people handled. This is important, for when planning a new building, you should eliminate waste space but at the same time have adequate room to avoid crowding during the busy times of the day. Our visiting hours in the wards are from two to three daily and from seven to eight on Tuesday, Thursday, and Saturday evenings, and while we allow two visitors to each patient, we are not crowded for room at any time. Our daily average admittance of patients is twenty-eight, or a little over 10,000 a year. Of this number, about one-fourth pass through our social service department, which, as you will see by the chart is in close proximity to the room clerk, being only a few feet from his desk and the examining rooms. Our ambulance service is light compared to the number of patients admitted, only 332 calls during the year of 1920. We have a daily average of about seventy-five doctors, while around 400 visitors pass through. Those visitors going to private rooms are not required to get a pass at the information desk, since they are permitted to visit from 9 a. m. to 9 p. m., except in serious cases when the attending physician orders the little "No Visiting" card hung on the outside of the patient's door. Most of the private room visitors pass in and out of the private pavilion entrance, where an attendant is stationed to direct them.

Personnel Required

The following personnel is required properly to handle the people and transact the business in the administration department: (24 hours' service.) Two at information desk, 7:30 a.m. to 9 p.m.; one at information desk, private pavilion, 8 a.m. to 5:30 p.m.; three room clerks, 7 a.m. to 10 p.m.; two cashiers, 8 a.m. to 9 p.m.; one bookkeeper, 8 a.m. to 5:30 p.m.; one assistant bookkeeper and bill clerk, 8 a.m. to 5:30 p.m.; three social service workers; two resident physicians, assisted by the interns; one night superintendent, and one assistant; two examining room nurses; one doorman (special policeman); one night man (special policeman); four bell boys.

In addition to these are the superintendent and his assistants, and the superintendent of nurses and her assistants, two record keepers in the history room, three stenographers, and seven telephone operators.

Routing Doctors

Now, if you will turn to the routing diagram, you will see that there is a double check on the doctors' coming and going. This is very important, for so many times a doctor slips in unnoticed, so that telephone calls and messages are undelivered, with the possible result that the patients in the waiting room are neglected. As soon as a doctor enters the front door, the telephone operator is notified, when she in turn calls the intern over the annunciator, "the still small voice" soon reaches him, no matter what part of the hospital he is in, and his attending man is announced.

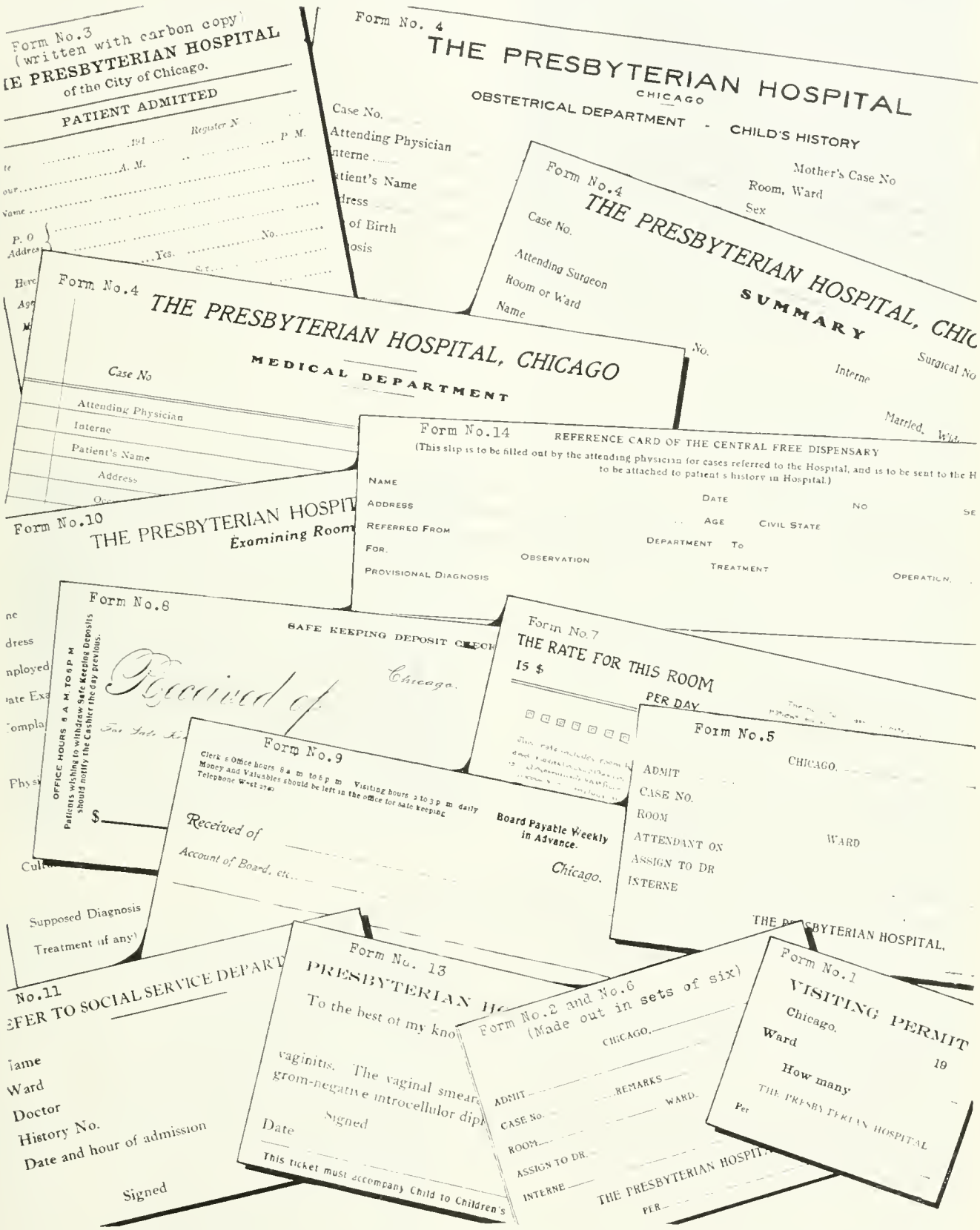
Routing Visitors

Visitors are handled without any trouble as per the routing diagram, form No. 1 admitting them to the elevator where the pass is taken by the elevator man instead of by the nurse on the floor. If for any reason more than the allotted number of visitors are at the bedside of a patient, the nurse reports the infraction of the rules to the office and the doorman is at once delegated to the floor and brings all but two down to the main floor. This plan works very well, making very much less trouble for the nurses, and creating very little annoyance to the visitors. When the visiting hour is up, the doorman makes the rounds of the wards and politely asks all remaining visitors to leave. We find this more satisfactory than ringing a gong. One of the bell boys looks after his station during his absence.

Routing Patients

Admission of patients requires the careful consideration of all with whom they come in contact, for here is where the first impression of the hospital is received. They should not be treated as "cases" but as patients. The members of the force should be carefully drilled to be courteous and not perky, to treat all patients alike, whether poor or rich. They should remember that the unpretentious man or woman appreciates kind and courteous treatment as well as others. Every patient that enters the hospital comes with the feeling that he can be better cared for than at home, so do not disappoint him before he is transferred

ROUTING FORMS USED AT PRESBYTERIAN HOSPITAL



The forms displayed above are some of those used in the efficient admitting department of the Presbyterian Hospital, Chicago

Foyer, main entrance of the Presbyterian Hospital, looking into the reception rooms.

to his room or ward. The clerk should say for example, "Take Mr. Singer to the examining room," not "Take the case to the examining room." Referring to the patient by his name instead of as "case" gives him a very different feeling toward the hospital.

There should be a place set aside for a wheel chair and some one person made responsible for it, so that when it is needed the attendant does not have to go to the floors and search for one while the patient is painfully waiting. Everything should be in readiness at all times, day and night, to prevent delay in getting the patient to his room. "Courtesy and Speed" should be the slogan in the admitting department.

Private Patients

We will now follow the routing diagram to the admitting clerk's office, and take up private patients or those who have been examined and sent in by or to a member of the attending staff. Many of these are for private rooms and have made their reservation, therefore so far as possible they are sent direct to their rooms and the record follows as soon as the admitting clerk gets the necessary data.

The original of Form No. 3 is used on the administration floor for making out the various records, such as patient's ledger sheet, social service records, history room, etc., after which it is filed for reference for one year. This is not held as a permanent record. A carbon copy is made, which goes to the attending man's mail box, and is then taken to his down town office for his own personal use.

There are three forms of Form No. 4 while only one is used, according to whether the patient is a medical, surgical, or obstetrical case. These are the beginning of the patient's record on the floor and are permanent, being filed in the record room when the patient leaves the hospital and the history is completed.

Form No. 5 goes to the nurse on the floor for her reference file and is returned to the cashier with patient upon his discharge. This provides the opportunity of settling his account and transacting any other business necessary for his discharge. The card is not kept for permanent record.

Form No. 6 is for the purpose of notifying all departments concerned that the patient is admitted. One goes with the patient to the nurse on the floor; one to the telephone operator who immediately notifies the intern; one is placed in the intern's mail box so he is sure to know that the patient is in; one to each information desk to be entered in the patients' door book for the checking of visitors, marking mail, etc.; and one to the nurses' office. These are not permanent records.

Form No. 7 is given to the patient, for the purpose of informing him as to the price of his

Room clerk's station, looking into the social service department.

room, extra charges, rules, etc., to avoid misunderstanding.

As the hospital is not responsible for money or valuables lost by the patients, it is necessary to provide proper protection for them, therefore all such articles can be placed in a package, sealed or otherwise, and deposited with the cashier, who gives a receipt for it, this being Form No. 8. Cancelled receipts are kept for five years.

Form No. 9 is a cashier's receipt. These are made in duplicate, the original being given to the patient and the carbon copy retained. These receipt books are kept for five years.

House Patients

House patients are those that usually apply personally for treatment and are not sent by an attending man or have no preference, therefore

it is necessary for them to be examined by the resident physician, to determine to what department they should be assigned. The clerk sends the patient to the examining room with Form No. 10, which is there filled out and returned with the patient to the room clerk, who makes out Form No. 2 and refers him to the admittance clerk, where the same system is carried out as in the admission of private patients. Form No. 10 however, is attached to Form No. 4, which goes to the floor with the patient, as a part of his record. Form No. 10 is a permanent record.

Charity Patients

Charity patients are handled the same as others, with the exception that they pass through the social service department on their way to the examining room, where a social service record is made, and attached to the patient's record after he leaves the hospital, and is a permanent record.

Patients returning for treatment are cared for in the same manner as upon their initial admission, except the various forms are usually made up from the previous history, thus avoiding the patients being delayed in the admitting office. He is sent to his room or ward and the forms, including his previous record, follow as soon as made up. When a patient leaves the hospital, carefully written reports from all departments are sent to the history room and become a part of his history. This includes the patient's ledger sheet, important correspondence bearing on the case, reports from social service, occupational therapy, x-ray and pathological laboratory which are filed with patients' records daily, hydrotherapy, diet, etc., in fact, when the history is pulled out of the files, it is complete, thus avoiding the delay of assembling it from the various departments. By sending the complete history to the floor, it enables the doctor to familiarize himself with the patient without any loss of time.

Information desk, bell boys' station at the right.

Admitting Children

So far as possible, all children under twelve years of age are admitted to the children's department; therefore, to prevent contagion, they pass through the examining room. Special attention is given to the throat, and for all females Form No. 13 must be sent with the child to the department. Form No. 13 is a permanent record.

We are affiliated with Central Free Dispensary and Rush Medical College, therefore a great many of our patients come through them. As they are examined by the physician and investigated by their social service department, we make no further examination, but admit them according to the information given on Form No. 14, which is a permanent record.

In conclusion, I wish to emphasize the fact that "Courtesy and Speed" should be our slogan in the admission of patients, for in how many of our institutions (to say nothing of doctors' offices) do they wait patiently, sometimes for hours, to be cared for.

ROCKEFELLER FOUNDATION GIVES SUMMARY OF WORK DONE IN 1920

The first installment of the review of the activities of the Rockefeller Foundation in 1920, written by its president, George E. Vincent, gives a summary of things done by the Foundation directly and through its departmental agencies, the International Health Board, the China Medical Board, and the Division of Medical Education, part of which is as follows: Aided six medical schools in Canada; gave a large sum to a medical training center in London; appropriated a million francs for the Queen Elizabeth Foundation for Medical Research in Belgium; agreed to contribute toward the complete rebuilding of the medical school of the University of Brussels; provided American medical journals and laboratory supplies for ten medical schools and medical libraries in five European countries; continued to construct and maintain in Peking, China, a modern medical school with a pre-medical department; aided thirty-one hospitals in China to increase their efficiency in the care of patients and in the further training of doctors and nurses; supported the School of Hygiene and Public Health of the Johns Hopkins University; contributed to the teaching of hygiene in the medical school at Sao Paulo, Brazil; provided fellowships in public health and medical education for ninety-three individuals who represented thirteen different countries; brought to the United States commissions of medical teachers and hygienists from England, Belgium, and Czechoslovakia; continued to support a campaign against yellow fever in South and Central America and in West Africa; aided government agencies in the control of malaria in ten states of the South; prosecuted hookworm work in ten southern states and in eighteen foreign countries; helped to expand anti-hookworm campaigns into more general health organizations in countries, states, and nations; brought a war-time anti-tuberculosis work in France to the point where it could soon be left entirely in French hands; assisted the government of Czechoslovakia to reorganize its public health laboratory system.

AVOIDING PSYCHOLOGICAL DAMAGE IN THE CARE OF HOSPITAL PATIENTS*

By HUGH CABOT, M.D., Professor of Surgery, Ann Arbor, Mich.

Hospitalization has become increasingly popular during the last half century. Much thought has been given to the construction and management of hospitals, but on the whole the points emphasized have been efficiency of management, avoidance of infection, and convenience of the hospital staff. One thing which seems to have been neglected is the avoidance of psychological damage to patients. It is an admitted fact that the mind has a marked influence on physical reactions, but this fact has not been taken into account in hospital procedure. If a determination is reached to avoid psychological damage, plenty of methods may be found to lessen it to a great extent, or perhaps to eliminate it.

THE most characteristic development of modern medicine as opposed to the medicine of a half century ago is the growth of hospitals, and the recognition both by the profession and the laity of the essential part played by the hospital in the scientific management of disease. We properly congratulate ourselves upon the achievement of early and accurate diagnosis and the consequent sound adaptation of therapeutics to disease. The average man has come to regard the hospital as the only safe place in which to be seriously ill or to subject himself to the dangers of a surgical operation. But it appears that in the development of hospitalization we have overlooked certain important by-products. We expend much thought, both in hospital construction and in management, on the avoidance of primary infection and of crossed infection, but in so doing we behave as if we believed that the people we treated had bodies but no minds. Hospital construction has, on the whole, held largely in view efficiency of management, avoidance of infection, and convenience of the medical staff. That these are important no man in his senses will deny, but that they are all-important seems to me open to argument, and it is this point which I desire particularly to bring to your attention.

It is no new conception that in disease the mind plays an important part in the reactions of the body. It is notorious that the influence of the physician and the nurse upon their patients is importantly affected by their personalities, perhaps quite as much as by their purely technical skill. We all of us can call to mind the physician whose mere presence in the sick-room has healing virtue, and many of our efforts would be without effect if we had not succeeded in convincing our patients of our ability to deal with them as a whole, and not solely with their bodies.

If, now, we come to consider the somewhat elusive thing which we may call hospital atmosphere, we may be willing to admit that it is an atmosphere of disease and of ailment, rather than an atmosphere of health. Almost from the moment that a patient enters a hospital he is surrounded by the manifestations of ill health, and can hardly avoid, at least under present conditions, picking up a quantity of suggestions wholly foreign to his own situation but which may importantly affect his outlook upon life in general, and his own share in life in particular. We who live and breathe the atmosphere of the hospital have probably forgotten that the mere odor of the hospital, the existence of which can hardly be denied, is gravely distasteful to many people, and hangs over them almost like a pall. Even the visitors to the hospital are affected by this atmosphere and if this be true, how much more must the patient, already in danger of being sorry for himself, be influenced. Many of you will remember Henley's poem "In Hospital," and perhaps many of you will have been affected as I was when I first read it by a feeling that he was exaggerating the case and at least using poetic license to transmit his meaning; but as time has gone on I have come to believe that his reactions were perhaps less rather than more than those of the average patient, that he differed only in his ability to make these sensations live, and was on the whole more lenient to us than he should have been.

You will of course realize that the dangers to which I allude are far more likely to affect certain individuals than others, but, in this day and age, the suggestible form a notable part of the community, and the number is probably increasing rather than decreasing. If we stop to think of it, it must be relatively clear that the effect on a sick, sensitive person of being projected into an atmosphere which reeks of disease and landing in a ward full of sick people, particularly as he himself has probably no clear conception of what is

*Read at the Annual Meeting of the Michigan Hospital Association, Ann Arbor, Mich., June 7, 1921.

the matter with him, is a pretty violent shock even to a sturdy temperament. If he is not too ill, and is in a receptive mood, he is likely as the days go on to take to himself the ailments of his neighbors and if by chance, he should find it impossible to make them fit his present disability, he may well store them up in his subconsciousness for use on some future occasion. For instance, I well recall a patient, who, having been long in a hospital with typhoid fever and being of the suggestible temperament to which I above alluded, years later reproduced for the benefit of his medical advisers symptoms of a patient who had occupied a neighboring bed and who suffered from advanced cardio-renal disease. So perfect was the mimicry, that the correct diagnosis was only arrived at after some time and with the greatest difficulty.

Psychological Effect in Surgery

Most of us will be inclined to admit that even under the best conditions of health and environment the business of living is sufficiently difficult. What then, is likely to be the result of adding to our burden when we are sick, the weight of the tragedy of the illness of others? Perhaps the most striking condition under which we on the whole disregard the psychology of our patients is in connection with the multitude of surgical operations which modern therapeutics requires. We have so accustomed ourselves to the machinery of surgical operations that we forget the effect they must have upon our patients. Because we did not ourselves dread the contemplated operation and might not, perhaps, were it to take place upon ourselves, nevertheless that operation is a severe strain upon the fortitude of any patient. We commonly fail to make any allowance for the fear which may amount to terror in our patients, and frequently expose them to unnecessary contact with the paraphernalia of surgery. I am convinced that the practice of bringing a patient to the operating room conscious is a gratuitous insult to his nervous system, and that the not uncommon parade of gowned and bemuzzled nurses, assistants, and surgeons, suggestive more of a butcher shop than a delicate therapeutic procedure, produces lasting impressions. The night before these ordeals is commonly a pretty dreadful business and accounts for not a few of the cases of unduly or unexpectedly rapid pulse rate at the beginning of the operation. Relatively few of us face the unknown with equinimity, and yet to most patients surgery is an unknown and a more or less dreadful business. We might, if we would, protect them during the previous twenty-four hours by the administration of harmless drugs to dull the acuity of consciousness. We might, if we would, assure them a profound if artificial sleep, and we might avoid for them the procession to execution in the full acuteness of consciousness. This is no new doctrine. Crile has long preached it; we all practice it under special conditions where we fear the effect upon nicely balanced nervous systems, but on the whole we are thinking so much of the technical, mechanical questions involved, and so much of the importance of efficiency that we forget that we are dealing with a living thing at all. Those of you who have had much experience in the care of physicians under such circumstances will realize that their familiarity helps them but little and that they are often willing and able to voice their complaints of our disregard of what we have come to look upon as trivialities. I take it that I need not stress the point that fear may be an engine of destruction, but it is perhaps not out of place to remind you that patients have actually died of fright not only before the operation had begun but before the anesthetic had even been administered. This is but an exaggeration of what every patient feels and yet on the whole we notoriously disregard it.

Remedies Suggested

If I have succeeded in making clear in this brief time the dangers which appear to me to surround our patients as the result, to a considerable extent, of being in the hospital, you will properly inquire what remedies are suggested. The most important remedy that I suggest is that we face these facts squarely, appraise their importance and constantly bear them in mind. If we are determined to avoid gratuitous insult to our patients we shall find plenty of methods which may be employed. An open ward is in this regard objectionable and becomes increasingly so as we are compelled to quarter there patients who are actually sick or suffering. It might well be maintained that for convalescent patients and particularly for those of a markedly gregarious habit, the open ward was unobjectionable. It at least serves certain economic purposes and can perhaps not be abolished, but at least we can avoid placing side by side the newcomer, perhaps with some obscure internal derangement of his machinery, and the individual suffering from some tragedy of violence and giving audible demonstration of his suffering. We can recognize the fact that the human machine is wonderfully adaptable and that given the opportunity, the horrors of the hospital fade. It is to the newcomer that the first shock is most serious and I firmly believe that he is entitled to an amount of protection which he does not always receive. Intent rather than accident should govern the distribution of patients. Note should be made of their probable susceptibility

to suggestion, and questions of economic and personal convenience should be regarded as of secondary importance.

Perhaps there is nowhere that we can do more good, with less upsetting of our present machinery, than in the care and management of our patients from entrance, to the end of their surgical operation. I firmly believe that in some patients who require some relatively unimportant operation that the psychic trauma now incident to such a procedure may do more damage than the operation itself will do good. I would make bold to assert that in the planning and management of hospitals quite too much attention has been paid to the convenience of the surgeon and quite too little to the psychic rights of the patient. If we expect to maintain our reputation as Samaritans we must not continue to overlook this side of the problem as we are doing today.

NURSING EDUCATION ESTABLISHED AT WESTERN RESERVE UNIVERSITY

A department of nursing education has been established in the College for Women at Western Reserve University, Cleveland. Students wishing to enter the profession of nursing may enroll in the college this fall and in five years receive not only a diploma in nursing but a bachelor of science degree.

Miss Carolyn E. Gray, of New York, who needs no introduction to the readers of THE MODERN HOSPITAL, has been appointed head of the new department, with the title of associate professor. Miss Gray is highly qualified to fill this important post. The college and schools of nursing in Cleveland are fortunate in securing her.

The first two years of the course will be spent in the College for Women, the student taking the regular college studies required for a bachelor of science degree, which will include the basic sciences required for nursing. The next two years will be spent in such Cleveland hospitals as meet the standard set up by the special committee which has the organization in charge. The fifth year will be elective, the student specializing to prepare for public health nursing, teaching and administration in schools of nursing and in other branches.

The new department has the support and endorsement of the Welfare Federation of Cleveland, the president having appointed a special committee to work with the university and hospital officials in establishing and perfecting the organization.

Students must be graduates of accredited high schools and must be able to matriculate with the College for Women. They must also be able to meet the requirements of the schools of nursing with which the department is affiliated.

PEKING UNION MEDICAL COLLEGE TO BE DEDICATED

Plans were recently announced for the dedication of the new buildings of the Peking Union Medical College, erected by the China Medical Board of the Rockefeller Foundation. The ceremonies will fill the week from September 15 to September 22, and will include an international medical conference to which scientists from America and European countries as well as from the Far East have been invited. At the same time will occur the inauguration of the director of the College, Dr. Henry S. Houghton, and regular sessions of the institution's board of trustees which is composed of representatives of the Rockefeller Foundation and of six missionary societies which had maintained an earlier medical college in Peking.

In preparation for the meetings and conferences the secretary of the Foundation, Mr. Edwin R. Embree, who serves as executive officer of the board of trustees of the college, sails for China leaving New York June 22. The following members of the board of trustees will sail during the summer and be in Peking for the meetings:

Dr. George E. Vincent, president of the Rockefeller Foundation; Dr. Paul Monroe, chairman of the board of trustees; Mr. John D. Rockefeller, Jr.; Mr. Martin A. Ryerson of Chicago; Dr. William H. Welch, of Johns Hopkins University; Mr. J. Oriol Armitage, of the Society for the Propagation of the Gospel in Foreign Parts, England; Mr. James L. Barton of Boston, secretary of the American Board of Commissioners for Foreign Missions; Mr. F. H. Hawkins, of the London Missionary Society, England; Mr. J. Christie Reid, of the Medical Missionary Association of London, England.

The following medical scientists from the Western Hemisphere have accepted invitations and will be present to take part in the international medical conference:

Dr. William H. Welch, Johns Hopkins University; Professor Tuffier of Paris; Dr. A. B. Macallum, McGill University, Montreal, Canada; Sir William Smyly of Dublin; Dr. R. T. Leiper, London School of Tropical Medicine; Dr. Francis W. Peabody, Harvard University Medical School; Dr. George de Schweinitz, University of Pennsylvania; Dr. Florence Sabin, Johns Hopkins University; Dr. S. S. Goldwater, Mount Sinai Hospital, New York; Dr. Thomas Cochrane of London; Dr. J. G. Clark, University of Pennsylvania; Dr. Victor G. Heiser, International Health Board; Dr. Richard M. Pearce, Rockefeller Foundation.

The Peking Union Medical College, situated in the capital of the Chinese Republic, had its beginning in an earlier institution, the Union Medical College, founded in 1906 by the joint efforts of six British and American missionary societies. The property of the earlier school was transferred in 1916 to the China Medical Board of the Rockefeller Foundation, which has purchased additional land and erected, in an interesting adaptation of classic Chinese architecture, a series of hospital and laboratory buildings. The institution comprises not only the medical school, but also a two hundred and fifty bed hospital with out-patient clinics, a nurses' training school, and a premedical school, an institution of junior college grade, with a distinct faculty and group of laboratory and classroom buildings.

PUBLIC HEALTH INSTITUTE POSTPONED

The public health institute which was to have been held in Washington, D. C., during November, 1921, according to announcements made in the Public Health Reports for May 13, 1921, has been postponed. After the announcement was made conferences were held between officers of the Public Health Service and officials of the American Public Health Association, and it was decided to postpone the institute indefinitely. This action was taken because the public health service desires to cooperate in every possible way with the American Public Health Association, in making a success of its semi-centennial meeting, which will be held in New York City, November 14 to 18. In connection with this meeting certain clinic demonstrations and possibly a health exhibit will be given.

BABIES' AND CHILDREN'S HOSPITAL OF CLEVELAND

By H. J. GERSTENBERGER, Medical Director; ABRAM GARFIELD, Architect, Cleveland; S. S. GOLDWATER, Consultant, New York

ON JULY 6, 1906, the Infants' Clinic of the Milk Fund Association and Visiting Nurse Association was opened, at the suggestion of Dr. J. H. Lowman, as a station to care for sick infants of needy families, and also to keep healthy infants well. In December of the same year this clinic was reorganized as the Babies' Dispensary and Hospital, mainly through the efforts of Dr. Edward F. Cushing, who for a number of years had been interested in the establishment of a hospital for sick infants and young children. Under the impetus of the first enthusiasm, funds were raised to buy land on East Thirty-Fifth Street, and for the erection of an ideal group of buildings. Plans were drawn for the erection of a dispensary building, a hospital building, a milk laboratory, and a nurses' home. The dispensary building was finally built during 1910, and opened during June, 1911. It remains today, a model of practical arrangement and construction.

In the few years following, the idea of establishing a new group of university medical buildings was definitely crystallized. The Babies' Dispensary was made a member of this group, with the understanding that it was to represent the Department of Pediatrics of Western Reserve Medical School. This, of course, necessitated an enlargement of the original idea of the function of the Babies' Dispensary and Hospital.

In order to fulfill the requirements of a modern pediatric clinic of a university medical school, it became necessary to rearrange the plans to include children from birth to fourteen years of age. In this group belong the newly born, and infants and children ill with contagious diseases. For the latter, provision has been made by setting aside the second floor of the hospital building as an independent unit, while opportunity to care for and study the former will be made possible by close cooperation with the department of obstetrics, whose building, the Maternity Hospital, will be located in immediate proximity to the Babies' and Children's Hospital.

It is, of course, understood that although no provisions have been made in this building for the preventive care and study of well infants and children, an active interest in this work, either, as at present, through intimate cooperation with the Bureau of Child Hygiene of the Department of Health, or through stations directly under the control of the Pediatric Department, will be maintained, in order that medical students and postgraduate physicians as well, will have opportunity to acquaint themselves with the extremely important and rapidly growing field of preventive pediatrics. This activity may assume such proportions as to require for its adequate development the entire attention and time of one individual, and for this reason the office of a welfare director has been made a part of the administrative scheme of the hospital, as indicated in the following:

Units of Division

A—For Patient:

(*a*) *Age:*
- (1) Birth to one year.
- (2) One to three years.
- (3) Three to fourteen years.

(*b*) *Cost of Service:*
- (1) Public wards.
- (2) Semi-private wards.
- (3) Private rooms and suites.

(*c*) *Illness:*
- (1) General—non-surgical diseases.
- (2) Contagious diseases.
- (3) Psychopathic conditions and diseases.
- (4) Premature infants.
- (5) Surgical cases requiring skilled feeding and nursing attention (pylorospasm, harelip, brain hemorrhage).

B—For Hospital Operation:
(Offices on first floor.)

(*a*) *Administration:*
- (1) Superintendent and staff.
- (2) Medical director.
- (3) Superintendent of nurses.
- (4) Social service.
- (5) Welfare director.

(*b*) *Care of Patients:*
- (1) Private rooms and suites, including contagious diseases.
- (2) Semi-private rooms, including contagious diseases.
- (3) Public wards.
  - (aa) Admitting ward.
  - (bb) General wards for various age groups.
  - (cc) Contagious wards, including steam room and operating room for intubation and tracheotomy.
  - (dd) Psychopathic wards.
  - (ee) Premature and wet-nurse suite.
  - (ff) Roof and porch wards (latter on north side for breeze effect in summer time, and on south side for sun effect in summer and winter).
- (4) Dental suite.
- (5) Surgical and operating suite for cases needing special pediatric supervision—pyloric stenosis, harelip, and brain hemorrhage.
- (6) Clinical laboratories, one on each floor.
- (7) Milk laboratory and diet kitchen.

(*c*) *Study and Research:*
- (1) Study and observation ward on floor just below library and research laboratories.
- (2) Living quarters for full time staff.
- (3) Medical director's room.
- (4) Library, and rooms for librarian, secretaries, and stenographers.

(5) Laboratories:
(aa) Chemical and physical.
(bb) Bacteriological, pathological and serological.
(cc) Respiratory and cardiographic.
(dd) Roentgenologic, photographic, cinetographic.
(ee) "Dieners'" room.
(ff) Animal suite.

(*d*) *Education:*
(1) Medical students:
(aa) Amphitheater, with adjoining demonstration and record room.
(bb) Wards.
(cc) Clinical laboratories.
(dd) Milk laboratory.
(ee) Social service.
(2) Nurses:
(aa) Amphitheater and lecture rooms.
(bb) Wards.
(cc) Milk laboratory and diet kitchen.
(dd) Social service.
(3) Medical staff, full time and part time; hospital *in toto.*
(4) Postgraduate students (physicians and nurses):
(aa) Amphitheater and lecture rooms.
(bb) Wards.
(cc) Clinical laboratories.
(dd) Milk laboratory.
(ee) Social service.
(5) Parents and public (amphitheater and lecture rooms, museum).

Arranging the Building

There are certain points which should be observed in arranging the building to meet the needs of the pediatric department:

(1) To make room and facilities available, at any hour of the day or night, for all of the work that today is considered a part of the function and activity of a department of pediatrics of a university medical school.

(2) To bring different divisions in close physical relationship with others that to a large extent are used in common for one or more pieces of work.

(3) To arrange the detail of each department, ward, room, or porch, in a manner that will meet modern ideas of interior requirements, and will also guarantee the greatest efficiency with the least expenditure of time and effort, especially walking and "elevatoring."

(4) To avoid unnecessary use of parts of the building as thoroughfares by individuals and groups that have no reason for passing through a given department or a part of the hospital.

The following are illustrations of the ideas in point:

(a) The research laboratories are on one floor, the uppermost. On this floor also are located the library, the medical director's rooms, and the living quarters for the full time staff. At one end of the fifth floor, just below this one, has been placed the study and observation ward, where it is planned to harbor infants and children whose diseases or conditions require a careful and sometimes prolonged study; for instance, cases of disturbed nutrition in which different types of balance studies are to be made. In such work it is essential that the nursing staff in charge of these children know all the pitfalls, and appreciate the great importance of accuracy and completeness in collecting and conserving material, and making observations. Such work will be much more dependably done if it is concentrated in one ward whose nursing staff will be as permanent as it is possible to make a nursing staff, and which staff, as a result of its long experience, will make this work as free from mechanical and other errors as it can possibly be. Such a ward and nursing staff will greatly relieve the anxiety of the research worker, will save time, and increase the dependability of the work as a whole.

So the study ward, the library, the research laboratories, with the small animal quarters, the medical director's room, and the living quarters for the full time staff, are in extremely close proximity, and, as a result, will unquestionably save effort, time, and produce more results.

(b) The wet-nurse suite has been placed adjoining the premature suite and on the floor where all of the infants will be kept.

(c) The contagious ward cannot very well be placed on the first floor, as, logically, this space must be occupied by the administrative offices, the social service rooms, the admitting ward, and the information bureau. Yet if the contagious ward is to be placed in the same building it should be adequately isolated from other divisions and, therefore, must have a separate elevator.

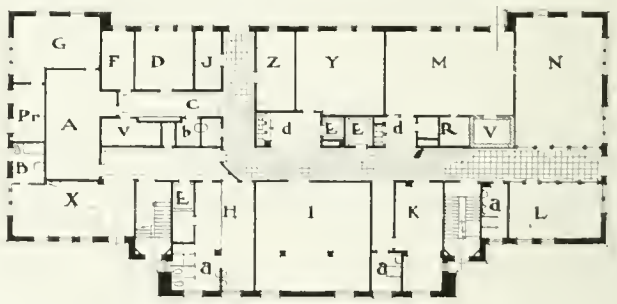
The smaller number of floors the elevator has to pass to get to the contagious wards the cheaper will be the cost of the elevator and the greater will be the space saved for small room and service purposes. Thus the contagious wards and rooms fill the second floor.

(d) Parents and friends of children occupying private rooms are quite free to come and go as they please. As a result, they will be a factor in limiting the always relatively inadequate elevator service of a tall building. Consequently, the private rooms have been placed on the next floor, that is, the third floor, and the one just above the contagious and the admission floors.

(e) Porches and roof gardens are used to give patients an unlimited amount of fresh air. In addition, in some cases sunshine is especially sought, and in others breezes.

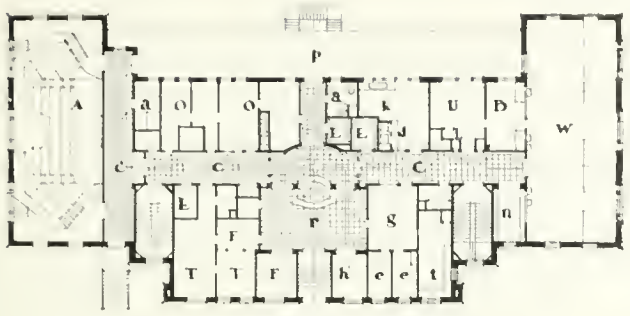
In the summer time, when the temperature and humidity are often excessively high, and when many infants are ill with diarrhea, and others and young children are uncomfortable in the heat, we are desirous of avoiding the sun and anxious to get as great a number as possible into the path of the breezes. From a study of the reports of the United States Weather Bureau Station located in Cleveland, it has been learned that approximately from May to October, and from 10:00 a. m. to 6:00 p. m., the breezes come from the lake, that is, from the northwest, north, and northeast. During the remainder of the twenty-four hours they come from the opposite directions, the southeast, the south and the southwest, and strike those parts of the building where the patients are kept in rooms and wards during the late evening, the night, and the early morning.

Therefore the larger porches have been placed on the northerly side of the building, and inasmuch as it is planned to give as many as possible of the inmates of the hospital the benefits of the breezes during the hot summer months, these porches have been made as roomy as possible, and have been arranged as outdoor wards. They have been placed along the side of the building har-



PLAN OF BASEMENT

A—Ampitheatre.
a—Toilet.
B—Bath and changing room.
b—Cleaners' closet.
C—Corridor.
D—Autopsy.
E—Elevators.
F—Waiting room.
G—Preparation chart and specimen room.
H—Nurses' dressing room.
I—Machinery room.
J—Janitor's room.
K—Drug room.
L—Mothers' and nurses' lecture room.
M—Milk laboratory.
N—Museum.
Pr—Projecting room.
R—Refrigerators.
V—Record and storage room.
Y—Linen and sewing room.
Z—Storage.



PLAN OF FIRST FLOOR

A—Ampitheatre.
a—Toilet.
B—Bath and changing room.
C—Cleaners' closet.
E—Elevators.
e—Examining rooms.
F—Waiting room.
g—Admission hall.
h History and sociology.
k—Diet kitchen.
n—Museum.
o—Office.
P—Porch.
r—Lobby.
T—Medical director's examining room.
t—Clinical laboratory.
U—Utility room.
W—Ward.

boring the service rooms, and the diet kitchens. These open directly onto the porches, just as do the hospital wards themselves, so that it is possible to come directly out of the service room, diet kitchen, or big ward onto the porch and back again, without circulating in a round-about manner in the common meeting place, the inner corridor of the hospital. The facilities for exposure to sunshine will also be ample, as small porches have been placed on the south side of the building, and as a large part of the roof can be used for the same purpose, the remainder having been arranged as a protected open-air ward for children that are to be in the air day and night over long periods of time.

(f) The amphitheater occupies the basement and the first floor in the dimensions of one of the wards, and is located under one of them. The entrances, toilets, wash rooms, coat racks, etc., for students and public are separate from the rest of the hospital, for the express purpose of eliminating the unnecessary use of the hospital facilities by students and outside audiences.

Separate entrances for contagious cases have likewise been arranged both from outside into the hospital and to the contagious floor, through the use of a special elevator, as well as from the contagious floor to the amphitheater.

Washing facilities, etc., have been conveniently arranged for in the amphitheater, in order that aseptic nursing technique may be employed there when infectious or contagious diseases are demonstrated.

Adjoining the amphitheater, and opening directly into it, is the preparation, demonstration, chart, lantern slide, and record room. This facilitates the preparation of material and the use of specimens, records, etc., both for clinic purposes and personal demonstration or instruction before or after the clinic, for instance, with microscopes. In this room the active staff can at a moment's notice, even during a lecture, prepare new or get old material for demonstrating purposes, without being required to hurry to a laboratory six floors away. Outside of lecture hours this room acts as a store-room where valuable permanent specimens, charts, slides, photographs, etc., may be safely kept under lock and key.

(g) The x-ray, photographic, and cinetographic laboratories are grouped in one suite, as they should be. It may seem strange, however, that a special building like the Children's Hospital should have this equipment when a central x-ray, etc., laboratory for the entire group will exist. The reason is that it happens time and again that a patient will present an interesting condition at an hour when the regular central x-ray and photographic staffs are off duty. Likewise, research work occasionally calls for continuous observations throughout the entire twenty-four hours. It is difficult and often impossible to have the staff of the central laboratory large enough to be able adequately to handle the special problem of a given department. This argument applies most logically to the development of the use of moving pictures as a teaching medium. For instance, it will be well worth recording, for lecture purposes, convulsions of various types, and there is of course no time schedule that one can follow in obtaining them for photographic record. The pediatric investigator and teacher is and must be ready to give his time and ability at any hour of the day or night, but frequently is prevented from recording valuable observations by the absence of members of the routine laboratory and technical staff of the central general group laboratory.

This is, of course, a perfectly normal condition, as it is clear that no staff can continue working day and night. The investigator who is especially interested will make up his loss of sleep in a few days by stealing so-called recreation hours for this purpose.

These laboratories have been placed on the general laboratory floor in order that they may be used for experimental animals as well as for patients of the hospital.

(h) A clinical laboratory has been placed on each floor. These laboratories are not large, but have been completely equipped so that all of the regular, routine chemical, microscopical, bacteriological, etc., tests can be performed there. This arrangement saves time for the interns, provides working space for the clinical clerks, and avoids the wasteful disturbing of the more advanced workers in the main laboratories on the sixth floor.

Aseptic nursing is of extreme importance not only in the contagious division of the Children's Hospital, but in the other parts as well. To what degree this truth has been appreciated in the proposed Babies' and Children's Hospital will be realized when it is pointed out that the internal ward and room arrangement is exactly the same for the non-contagious as it is for the contagious rooms and wards. Cubicles are planned for each ward patient, and adequate, accessible and time-saving hand-washing facilities are assured. In the wards the washstands are arranged in three groups of two each.

The cubicles, as can clearly be seen from the ward floor plans, group themselves in three rather definite divisions, one for each four beds, and the other two for four or five. Directly opposite each of these cubicle groups are placed one pair of washstands, making the so essential and frequent washing of hands easy and possible with almost no walking. The relatively large number of washstands also avoids loss of time caused by one nurse waiting for another to finish washing her hands. The great amount of time saved will be especially evident when rounds are made by the medical men and when clinical clerks are taught. At such times usually three or four individuals are anxious to wash their hands at the same time. In our opinion the cubicle and the washstand arrangement represents possibly the most finished and important detail in the entire institution.

The Type of Building

The building will be six stories high, of fireproof, steel frame and brick construction, with an "all-year-around" fresh air ward on the roof, with a high basement and a sub-basement, the latter for communication with the corridor that will connect the Children's Hospital with the laundry, kitchen, and other buildings of the general group, but especially with the Maternity Hospital. The latter building is directly east of the Children's Hospital, and in closer proximity with it than with any other building. This is as it should be, for in the care of the newly born a most intimate cooperation between the obstetric and pediatric departments is essential for the welfare of the infants, and for the further study of this stage of infantile existence.

The general location of the building is at the southwest end of the twelve acre plot which will harbor the entire group. Both buildings face on the south the front of the medical school, which is separated by a plaza approximately one hundred and fifty feet wide.

To the north of the Maternity and Children's Hospital are the rest of the hospital and service buildings, the nurses' home and a special ward building being the nearest.

The form of the building is a somewhat modified "U" shape, the arms of the "U" being very short, and with the principal northerly porches subtended between the arms.

It has been pointed out above that provisions have been made for sun porches, "breeze porches," roof sun space, and a fresh air roof ward.

Interior Equipment of the Building

The heating of the building is accomplished by the medium of low pressure steam, delivered into the building from a nearby power plant, through a pressure reducing valve operated as a vacuum system.

The large wards, and several special rooms, are under thermostatic control.

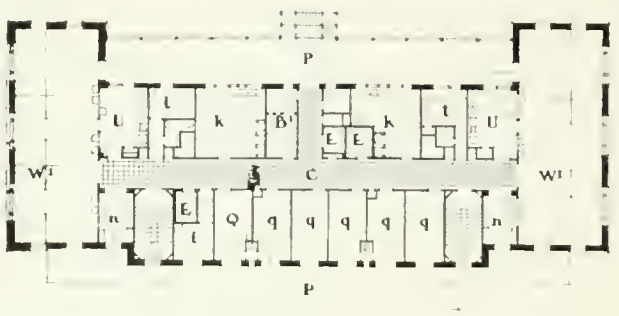
As it is desirable to maintain heat in some few rooms during periods of the year when the general heating apparatus is no longer in use, such rooms are supplied with steam through small reducing valves, directly from the medium pressure steam system, which supplies steam also for diet kitchen and sterilizers, and is therefore in operation the year around.

One of the interesting features of the heating equipment is the treatment of "premature rooms," which are to be used for the care of prematurely born infants, and which must be maintained at not only a very even temperature, but also at a very even degree of humidity.

To accomplish the desired result, such rooms are individually equipped with a heating apparatus, subdivided into heating and cooling devices, and with a humidity apparatus, subdivided into humidifying and de-humidifying devices.

The Ventilating System

The humidifying apparatus without the de-humidifying device is also installed in each of the large wards. The ventilation of the building is accomplished positively by means of electrically operated, fully enclosed fans of the modern, multiple blade design, located in apparatus rooms in the attic. The system of ventilation is mainly of the exhaust type. The apparatus is composed of several units, each separate from the others, and for distinctly separate service. Operating rooms, assembly rooms, etc., are ventilated by the "main vent fan" with its system of sheet metal ducts and registers. Toilets, utility rooms, and rooms of similar use, are ventilated by a "toilet vent fan," with its separate system of ducts and registers. The premature room group, the milk laboratory, the contagious section of the building, the motion picture booth, and the group of laboratory hoods, are each ventilated by separate apparatus. In order to assure thorough ventilation when doors and transoms may be closed, a space is designed under the bottom of all doors, thereby permitting a current of air inward to the rooms from the corridors, and preventing odors passing from one room to another.



PLAN OF SECOND FLOOR

B¹ Discharge bath.
C Corridor.
E—Elevators.
i—Inhalation room.
k Drug room.
l—Linen room.
n—Museum.
P—Porch.
Q—Tracheotomy and intubation room.
q Private room.
t—Clinical laboratory.
U—Utility room.
W¹ Contagious ward.

In addition to the general heating and ventilation apparatus, the building is further furnished with compressed air, vacuum, and gas equipment for laboratory purposes, with a medium pressure steam system for utility rooms, diet kitchens, etc., and with systems of refrigeration and vacuum cleaning.

Features of Mechanical Equipment

Gas service is taken from the city mains; compressed air and vacuum pumps are located in the power plant and piping extended into the building; piping for these three systems is extended through the building and under laboratory tables, terminating with laboratory cocks on the tables.

The medium pressure steam system, extended to the building from the power plant, supplies steam to the various sterilizers, stills, blanket warmers and drying rooms, diet kitchen fixtures, and laboratory equipment.

Refrigeration machinery is located in the power plant, and cold brine mains are extended into the building, thence to the various refrigerated rooms and compartments, such as food refrigerators, milk refrigerator in milk laboratory, mortuary, premature rooms, etc., and to the drinking water cooling tank. The vacuum cleaning apparatus is of the modern central plant design, the motor driven machine being located in the attic, with a system of piping extending down through the building, terminating in hose valves on the several floors. The apparatus is designed to be electrically operated from any floor where it is de-

sired to conduct sweeping operations. A complete set of hose and various cleaning tools are supplied for each floor.

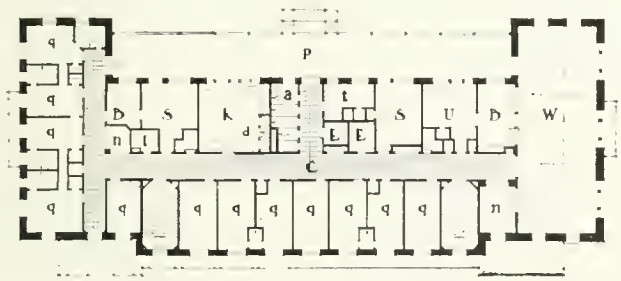
Lavatories and Baths

The wards are fitted with lavatory basins of vitreous china, of special sizes to fit the various spaces, and arranged to be operated by foot and knee valves.

Several rooms are fitted with lavatories of all white vitreous china, equipped with combination valves with diffusing sprays for washing with running water, the valves being designed for operation by elbow or by hand, as may be desired.

Toilet room water closets have sanitary flushing extended fronts, non-absorbent white seats open front and back. In the juvenile toilet rooms the water closets are of special low height.

Bathrooms are fitted with white porcelain bath tubs for adults, and set at a convenient height for the nurse. Baths for babies are of white porcelain, against the wall, set at proper height and fitted with non-scalding thermostatic mixing device.



PLAN OF THIRD FLOOR

Ba—Balance room.
C—Corridor.
E—Elevators.
k—Drug room.
l Linen room.
n—Museum.
P—Porch.
q—Private room.
S—Semi-private room.
t—Clinical laboratory.
U—Utility room.
W—Ward.

Both types of bathtubs are also fitted with slabs and so can be used for slab bathing, which in this hospital will be given preference over tub bathing, the plan being to use the latter mainly for special therapeutic purposes.

Numerous Electrical Systems Used

The electrical equipment for any specialized teaching and clinic hospital, such as the Babies' and Children's Hospital, consists of numerous systems, there being general illumination which is the lighting for various rooms; general power, which is the elevators; ventilating fans and miscellaneous utility apparatus; special electric power and heating equipment used in laboratories, diet kitchen, x-ray departments, etc.; telephone equipment for general communication; and in conjunction with the same, the doctors' signal system for calling doctors at any location in the hospital to the nearest telephone, consisting of lamp annunciators controlled by the telephone operator; nurses' calling systems for the patient's bedside call to the nurses, consisting of lamp signal with audible detachments; electric time clocks; electric watchmen's systems; electric fire alarms; and electric cardiograph.

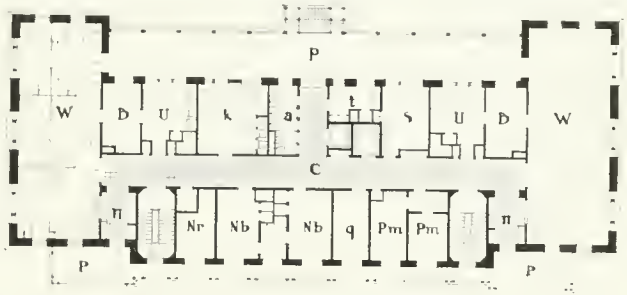
There are also necessary in such an equipment many electric utility outlets for electrical reaction apparatus, fans, electric stoves and heating pads, and many other conveniences, among which are an electrical floor scrubber, and electrically operated vacuum cleaners.

The lighting of the wards and rooms is a combination of indirect and local source of light arranged in such a way as to take into account the comfort of the patient under varying conditions. Transoms of windows are opaque so that the light from above is avoided while ventilation is possible. This direct form of ventilation is obtained by mechanically operated transom adjusters which are concealed, and also by additional flap doors to the rooms, which are light wood frames covered with cloth. The cloth is easily removable for washing.

Windows Are Double Hung

Windows generally are double hung and double pivoted so that they may be cleaned from the inside, and also to govern the ventilation of the rooms. Opening onto the balconies are French windows with the sills at the floor line, so that beds may be readily rolled out and in. The windows open in and the screens open out at right angles, so that the patient is partly screened from adjoining windows. Window and door trim is of metal and flush with the plaster. All doors are metal, but the sash and frames of windows are generally of wood.

Linoleum in wide strips cemented to the concrete is the general floor covering. In the corridors this system prevails, using a strip six feet wide and with a terrazzo border and base. A ter-



PLAN OF FOURTH FLOOR

a—Toilet.
B—Bath and changing room.
C—Corridor.
k—Diet kitchen.
Nb—Wet nurse's bedroom.
Nr—Wet nurse's sitting room.
n—Nurses' station.
P—Porch.
Pm—Premature.
q—Private room.
S—Semi-private room.
t—Clinical laboratory.
U—Utility room.
W—Ward.

razzo base sloping out enough to throw the hub of the carriage clear of the plaster wall is used in all corridors, public wards, and most public places. The private rooms have a vertical metal base, flush with the wall and floor. The floor of the amphitheater is of asphalt.

A laundry chute centrally located takes care of the entire building except the contagious ward. For this ward a chute is inadvisable and laundry is taken out in bags. The method is rudimentary but correct.

Milk Kitchen and Diet Kitchens

While the central kitchens will supply food in bulk, the particular needs of this hospital are covered by a milk kitchen, where the milk is modified to its different uses. This work can receive the supervision required only if it is done within the walls of the building. Dumb waiter service to the diet kitchens on each story is the most suitable method, taking the materials into account. Refrigeration is an important feature in milk preparations, and each diet kitchen has its own cooling box, refrigerated from the central plant.

Particular attention has been paid to the question of cupboards. Those in the diet kitchens, and where an unusual amount of cleaning is necessary, are of enameled metal. Cupboards in linen and storage rooms are of wood. All are arranged so that no lodging place for dust is left on top, by furring down and plastering flush with the face of the cupboard. Cupboards are not planned higher than seven feet from the floor except in the case of a few storage cupboards where materials that are needed only occasionally may be kept.

Functions of the Individual Floors

The first floor is the administration and admission floor. In one half of it are located rooms for the superintendent and his staff, a suite for the medical director for the examination of private patients, a general waiting room and the upper half of the amphitheater, which, however, is entirely separated from the rest. In the other half of this floor is the admitting suite, consisting of a waiting room for patients, a social service room, two admitting cubicles, a clinical laboratory, and an admitting ward of fourteen beds with its bathroom, diet kitchen and utility room, and two elevator shafts, one for general patients and the other for contagious cases. The latter does not open on this floor. The entrance lobby, circular in plan, harbors in its middle part the information and telephone central, while in the rear third are found the passenger elevators and toilets.

The second floor is devoted entirely to contagious cases. It is the only floor that has two diet kitchens. This arrangement makes possible dividing it into distinct units which may be operated independently of each other. It is also different from the other floors in that it has but one bathroom, which is used only at the time of the discharge of patient, the admission bath being given in the contagious admitting suite in the basement. During treatment, bed baths will be the rule. A small hallway just outside of the elevator is distinctly separated from the main corridor and the rest of the contagious floor. It is considered to be just as free from contagion as any other part of the hospital. It is here that parents and friends of patients to be discharged may come to get them. The general passenger elevator stops here also.

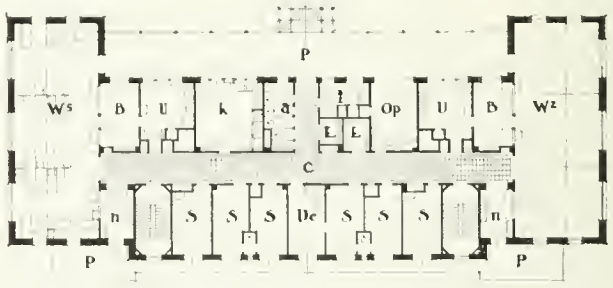
The sun porch space on the south side of the building has been decidedly increased for the contagious floor, by increasing from three to ten feet the width of the balcony which on the other floor connects with two small sun porches placed at the south ends of the large ward on each floor. This additional sun porch space has been provided because it will not be possible to take cases from this floor to the roof where patients from all the floors may be brought together.

Typical Ward Floors

The ward arrangement on the contagious floor is not different from that of any other floor. This is due to the fact that on the non-contagious floors every precaution has been taken and every arrangement applied to lessen the spread of infectious and contagious diseases.

As a result of this plan, the entire hospital, or any part of it, could in an emergency be used as an ideal contagious hospital.

The third floor contains a regular ward for children from two or three to fourteen years. Connected with the ward are regular baths and utility facilities. At the other end of the floor the space occupied on other floors by the second



PLAN OF FIFTH FLOOR

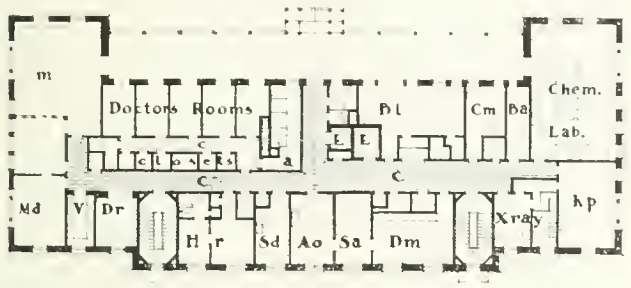
a—Toilet.
B—Bath and changing room.
C—Corridor.
De—Dentist.
E—Elevators.
k—Drug room.
n—Museum.
Op—Operating and examining.
P—Porch.
S—Semi-private room.
t—Clinical laboratory.
U—Utility room.
W²—Psychopathic ward.
W⁵—Study ward.

ward has been arranged in four rooms for private patients. Each room is connected with a separate bathroom and closet, and two of the rooms are large enough for the placing of two beds, one for the mother or nurse, the other for the child.

All four of these rooms are connected with each other through small hallways which may be closed or opened as desired, in this way making it possible to arrange these four rooms in suites of two, three, or even four individual rooms.

The space between the two ends of the floor on the south side has been divided into eight individual rooms, each containing an individual lavatory, and four having access to toilets, one toilet serving two rooms.

On the north side of the floor are located, besides the diet kitchen, utility rooms, etc., two semi-private wards of two beds each. One of



PLAN OF SIXTH FLOOR

Ao—Animal operating.
a—Toilet.
Ba—Balance room.
Bl—Discharge bath.
C—Corridor.
Cm—Cardiography.
Dm—Dieners media and cleaning.
Dr—Doctors' living room.
E—Elevators.
Hr—Head physician's living room.
Kp—Kinematography and photography.
Md—Medical director's office.
m—Library.
Sa—Small animals.
Sd—Shaking and drying.
V—Record and storage room.

these or a few of the individual rooms, closest to the ward for older children, may at any time be used as isolation rooms for the ward children.

The windows of the individual rooms on the south side of the building are to be built as "door windows" in order to permit the foot end or head end of the bed to be pushed out on the three foot balcony.

In other words, in this manner porch facilities are present for every individual in the hospital, as the sun porches and the large "breeze porches" on the north side will give adequate space for patients in the wards.

Porches Accessible from All Rooms

This does not mean that it will not be possible to take patients of individual rooms to the large "breeze porches" on the north side. In order to make the north porches accessible to the individuals housed in rooms on the south side of the building, a hallway has been arranged for on this floor as well as on every other floor, which connects the inner corridor of each floor with the large north porch of the same floor. (See plans.) This arrangement shortens the distances of travel and also makes unnecessary the passing through one of the large wards to get to the "breeze porches."

The Infants' Floor

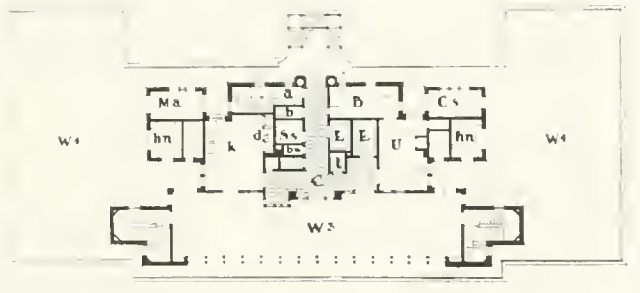
The fourth floor is devoted to infants, young children, premature infants, and wet nurses. The wet-nurse suite has been arranged for four wet nurses and consists of two bedrooms, one bath and toilet room, and one living room. Adjoining this is the premature suite of two rooms for three infants. Special ventilation, heating, and moistening equipment will be installed in this suite. On the south side of this floor, between the two wards, are the regular service rooms and one small semi-private ward of two beds.

The fifth floor is quite like the fourth, but it is devoted to other purposes, and it has the dental and operating rooms. The latter are to be used for infants that require the finest pediatric, medical and nursing supervision, as cases of brain hemorrhage, pyloric stenosis and hare-lip.

Psychopathic Ward

One ward is to be used for psychopathic cases. The other is called the study and observation ward, the function of which has been described in an early part of the article. On the north side of the corridor are seven individual rooms, one for the dentist, the rest for private and semi-private or ward isolation patients. Each room is again equipped with individual washstands, and four of the six have direct access to a toilet.

The cubicle, washstand, corridor, porch, service, record, telephone, clinical laboratory, head nurse's desk, linen cupboard, general toilet arrangement and the placing and interlocking of the individual parts with the idea of saving steps and time can best be appreciated by a study of the plan of this floor.



PLAN OF ROOF WARD

a—Toilet.
B—Bath and changing room.
b—Cleaner's closet.
bw—Blanket warmer.
C—Corridor.
Cc—Cot storage.
E—Elevators.
hn—Head nurses' storage.
k—Diet kitchen.
Ma—Mattress airing.
Ss—Stretcher and mattress storage.
U—Utility room.
W3—Fresh air ward.
W4—Open air ward.

Study and Research Features

The sixth floor is devoted entirely to study and research. At the end is located the library, large enough for 6,000 volumes. This room will also be used for board meetings. Adjoining it is a room with desk space for a librarian and a secretary to the medical director, whose office adjoins it on the other side. The medical director's room on this floor will be his headquarters, the rooms on the first floor being used solely for consultation work, and conference work with the superintendent. Next to the medical director's room is a fireproof record room. The remainder of the space of the west end of the building is used for the living quarters of six full time men.

The east half of this floor harbors the laboratories, the animal suite, and the balance room. The type of laboratories has been described in an earlier part of this article and the location can be seen from the floor plans.

The Roof Ward

On the middle third of the roof has been built a somewhat protected fresh air ward with fourteen beds with all necessary service additions. The patients in the fourteen beds can be protected from the weather to a varying degree just as desired. Both ends of the roof are tiled, so that patients may be brought from any floor to this part of the roof for exposure to sunlight. Awning arrangements have been provided to protect, when necessary, against excessive sun rays. On the roof is also located a large room for mattress airing and storage.

Basement Features

The lower half of the amphitheater is located in the basement, the upper half occupying a corresponding space on the first floor. Patients for the clinic are brought to the basement floor by elevators. On the non-contagious side a special waiting room for these patients has been provided. On the contagious side, which is completely separated from the other, the corridor from the elevator to the amphitheater is wide enough to be used as a waiting room. On the north side of the amphitheater is located the preparation and demonstration room, which was described above. At the other end of the basement are located a museum and a lecture room for nurses and mothers. In the mid-structure of this floor, on the north side, are the milk laboratory, linen and sewing rooms, on the south side space for machinery, storage, and a drug room. To the south of the amphitheater is the admittance suite for the contagious floor, which consists of a social service room, two examining cubicles and a bathroom, and which is connected by a wide corridor with the elevator which goes only to the contagious floor.

All the material brought to the hospital is taken to the janitor's office, which is located at the only entrance on the north side of this floor.

The sub-basement exists solely to make possible a connection with the service corridors of the other buildings in the group.

BELGIAN HOSPITALS UNDER ONE HEAD SAYS M. GOOSENS-BARA

M. Goossens-Bara, director of hospitals and charities of the City of Brussels, and M. Dowin, architect of the new hospital of St. Pierre, Brussels, who have been in the United States since July 10, as guests of the Rockefeller Foundation, for the purpose of studying types of hospital construction and administration, sailed July 30, for England where they will continue their investigations.

On the eve of his departure M. Goossens-Bara stated that his visit, short as it necessarily was, had been productive of numerous and important results.

"I hope," he said, "that it will enable us to introduce into Belgium the many improvements which we have noted here. It is with feelings of admiration and gratitude that we leave the hospitable soil of the United States where we have received a welcome that we shall never forget.

"We visited hospitals and medical schools in New York, Boston, Toronto, Montreal, Chicago, St. Louis, Cincinnati, and Baltimore. Most of the hospitals which we visited are superior, from the standpoint of arrangement, to the two hospitals in Brussels—St. Pierre and St. Jean, which, however, are more than one hundred years old. The superb new Brugmann Hospital at Jette will not be opened for several months yet.

"There is a fundamental difference in hospital organization in the United States and Belgium. In Belgium all the charitable institutions of a city, hospitals, homes for the aged, orphanages, etc., are under the management of a single body, the "Hospital Board" whose members are elected by the Municipal Council, which exercises a right of supervision. In Brussels, the hospital board is also entrusted, pursuant to a decree of Napoleon I, with everything relating to charitable assistance, that is, the relief of the indigent in their homes.

"In the United States and Canada, however, the greater number of hospitals are governed by their own private boards of trustees. The pronounced centralization of hospital management in Belgium is not without its disadvantages, but I think that in the final analysis it is to be preferred to the uncoordinated system in use here.

"The first and most important object of our visit here was to study methods of establishing a very close and complete connection between the new School of Medicine of the University of Brussels and the new Municipal Hospital which will replace the St. Pierre municipal hospital. This close connection must be given as much consideration in the construction of the hospital as in its organization and administration for teaching purposes. The information which we have been able to gather on this subject is most valuable and complete. Aided by it we hope to carry out a plan of work in line with latest improvements in hospitals and clinics.

"Special attention was also directed to three other problems, one of which was the position of the director of a university hospital, particularly the training which he should have and the powers which it is advisable to confer upon him."

THE DIAGNOSTIC HOSPITAL OF A SMALL COMMUNITY

By ROSWELL T. PETTIT, M.D., Ottawa, Ill.

There have been many changes in the past thirty years in everything in the hospital and medical field. The hospital has changed from a place in which the indigent sick were cared for to a place used by all classes. Medicine has been revolutionized by the discovery of the bacterial cause of disease, and the resulting application of asepsis and antisepsis to surgery.

In no field has greater progress been made than in that of diagnosis and diagnostic methods. But the smaller community hospitals cannot afford to provide the highest grade of diagnostic facilities. May the solution not lie in group diagnostic centers that are accessible to small hospitals?

ORIGINALLY the hospital was a refuge for the sick pauper, and on the same level as the alms house. A well-to-do person never thought of going to a hospital if he could help himself.

The status of the hospital has changed, however, especially during the past thirty years, until now it is used by all classes.

The evolution of the hospital has been consistent with the development of modern medicine, and greater progress has been made in medicine during the past thirty years than in the whole previous century; some writers have said than in the whole previous history of the world. This impetus to the science of medicine was due to the discovery of the bacterial cause of disease, and the resultant application of asepsis and antisepsis to surgery. This changed the hospital from a convenient place for the care of the indigent sick to a necessity for all classes. It has revolutionized hospital construction and appointments until today there is scarcely a hospital in the country, from the largest to the smallest, that does not boast of its sterilizing equipment and perfectly appointed operating room. All classes of people are now taken to hospitals, chiefly because it is the best place to perform major operations aseptically.

But while there has been a tremendous development in surgery, other lines of medical endeavor have also made progress along the same or similar lines, and in no field has greater progress been made than in that of diagnosis and diagnostic methods. This development in diagnosis, too, dates back to the time of the discovery of the bacterial cause of disease. With the development of bacteriology and the allied sciences of pathology and serology, the utilization of pathological and physiological chemistry, and the discovery and perfection of the x-ray, it is now generally recognized that the cause of the diseased condition must be determined before rational therapy can be instituted; that the treatment of symptoms alone is futile.

While this principle is generally admitted, outside of the large metropolitan hospitals the diagnostic function of the hospital, particularly in the smaller community hospitals, has been neglected, or rather undeveloped. While all these smaller hospitals are justly proud of their careful surgical technic and operating room equipment, not many of them can boast of a well-appointed laboratory and x-ray equipment, in the hands of experienced and competent workers.

Most hospitals in the smaller towns, by that I mean the towns of thirty thousand or less population, do not furnish the attending physician with high grade diagnostic facilities, for several reasons. The chief reason is the cost. The complete cost of a bacteriological, chemical, pathological, and serological laboratory is several thousand dollars, and a complete x-ray equipment, capable of meeting all requirements, costs several thousand dollars more; but even if these delicate instruments of precision can be and are provided, too frequently they are placed in the hands of persons of inferior preliminary training and a few weeks or months technical instruction. High grade apparatus should be provided, but what is more important is high grade technical service by skilled workers having good preliminary education and thorough technical training. Otherwise, these methods of precision, if improperly performed or improperly interpreted, are worse than useless, they are misleading and dangerous.

Diagnosis Most Important Branch

Diagnosis is the most important branch of medicine and surgery. Before therapy can be instituted a diagnosis must be made. It goes without saying that times have changed, that the doctor that depends upon a stethoscope, a clinical thermometer, and a few test tubes for his diagnostic equipment is not giving his patients all that is due them. But how is he going to avail himself of the more exact (not more important) methods

of examination? It is possible that he has the training necessary for carrying out these tests and examinations himself, but most frequently the busy practitioner cannot take the time to carry out these arduous procedures. Most of us depend upon others for assistance. We are not willing to let the office girl or nurse assistant percuss and auscultate our cardiac cases. We are not content to let the stenographer take our clinical histories. Is it any more reasonable that we depend upon the results of poorly trained assistants or nurses for our Wassermann tests, urinalyses, blood counts, and x-ray examinations? These procedures are of necessity medical and surgical in character, and while it is not necessary that all of them should be done by physicians, these examinations should be done under the direct supervision of a physician especially trained in pathology, bacteriology, and roentgenology.

Small Hospital Has Not Specialized Service

The small hospital, because of expense or other reasons, cannot usually furnish high grade specialized service of this sort to the physicians and patients that come to it. In the past the physician in the small town or city has taken the patient with an unusual or obscure condition to a specialist in the nearest large city. The specialist usually sends the patient to one of the large hospitals for observation. This observation, in large part, consists of the utilization of these same special, more exact laboratory methods of examination. The small hospital cannot afford them, the large metropolitan hospitals and specialists can.

This plan, so much utilized in the past, has not been entirely satisfactory in most instances to either the patient or attending physician; the former because of the expense and the necessity of going into a strange environment; the latter because too often he loses all contact with the patient, and still retains his responsibility to the patient and family.

The patient complains because he does not like the noises of the large city, too frequently he is compelled to pay more than he can afford for hospital accommodations, and he cannot have his friends come to see him, he is overpowered and overawed by his surroundings—he is not at home.

The general practitioner, the family doctor, complains because too frequently the whole matter of management of the case is taken completely out of his hands. He also feels there is too much "passing the buck," referring the patient from one specialist to another, with too little consideration, too much reduplication, and too many fees to be paid. The country doctor feels that he is entirely competent to give his patients good care. To be sure, he frequently asks the advice and assistance of a specialist or a colleague in a difficult or unusual case, but for the most part he feels that he is able to render competent service to the usual medical or surgical condition. In this he is right.

High Standard Among Country Practitioner

The standard of efficiency among general practitioners in the small towns is greater than among their counterpart in the large cities. This is easily explained. The country doctor must, very largely, depend upon himself. His great need, and no one realizes it better than he does, is assistance in diagnosis. With a diagnosis made, he is fully competent to decide whether or not it is feasible for him to undertake the treatment, or refer the patient to someone else.

A partial view of the Illinois Valley Diagnostic Hospital, in the construction of which a definite effort was made to depart from conventional types of hospital construction.

What the physician in general practice wants

is improved diagnostic facilities; the small hospital usually cannot afford the necessary equipment, or what is far more important, the services of a trained pathologist and roentgenologist with a thorough medical education. The large metropolitan hospital that provides these facilities is too far away, the patient refuses to go, and when he does go the attending physician resents the action of the specialist in taking everything into his own hands. What is the solution? Decentralization of diagnostic facilities from the large cities, centralization of diagnostic facilities among groups of small hospitals in the country, with formation of small, accessible diagnostic centers. To quote from a recent article by V. N. Leonard:[1]

"With a well-rounded organization at hand, equipped to do first class diagnostic work, the physician could send his patient to it for diagnostic study, much as he now sends his patient's blood to the laboratory for a Wassermann test. The patient could be returned to him with a report of the work done, a complete and accurate diagnosis, and full suggestions as to therapy; an organization handling a large amount of work could offer such service at a cost well within the reach of the average patient. In addition to its own work it could function as a diagnostic laboratory for the practitioner, and bear the same relation to him that the pathological laboratory bears today."

Ottawa Has Diagnostic Hospital

The Illinois Valley Diagnostic Hospital, Ottawa, Ill., is functioning as an institute of this sort. The plan, not as yet fully worked out, may be of interest to physicians and others associated with hospital work in other communities with small hospitals. It is endeavoring to fill the gap between the general practitioner in the smaller cities and towns on the one hand, and the large metropolitan centers and clinics on the other. It is not the aim of the hospital staff to undertake the treatment of cases except in conjunction with, or at the request of, the attending physician; its function is to do first class diagnostic work. The hospital is conducted as a private enterprise and is dependent upon the hospital fees for support; the fees charged, however, are consistently less than those charged for a similar class of work in the large centers and clinics.

The general laboratory. This laboratory overlooks the Illinois river valley, and has splendid north light.

Ottawa is a town of twelve thousand and has good railroad and electric interurban connections, east, west, north, and south, and hard roads within a radius of twenty-five miles. The hospital has accommodations for sixteen patients, and as the length of stay of the patient is usually short, three to seven days in most instances, and as a considerable group of cases can be handled as out-patients, this capacity has been found adequate to meet present needs and possibly future needs for several years.

Hospital Well Equipped

The hospital maintains a fully equipped bacteriological and pathological laboratory under the direction of the physician in charge, assisted by two trained technicians, one a chemist, the other a bacteriologist. The laboratory is prepared to make all established bacteriological, pathological, and chemical tests used in clinical medicine, under the direction of a physician. The laboratory, in addition to serving the hospital, also does clinical laboratory work for physicians in the sur-

1. Leonard: J. A. M. A., 76, 421.

rounding territory, the specimens being sent in by mail.

The hospital also has a fully equipped x-ray department, under the direction of a physician. The x-ray laboratory is equipped for all forms of fluoroscopy. The bulk of the x-ray work consists of fluoroscopy and radiography of the chest, abdomen, and genito-urinary tract. The work is not done by a radiographic technician or photographer, but by a roentgenologist, a medical graduate, and it is the policy of the hospital not to "take an x-ray picture" alone, but to make a roentgenological diagnosis not only in fractures and diseases of the bone but in lesions of the lungs, heart, gastro-intestinal tract, and urogenital tract.

This diet kitchen is equipped with thermos steel containers in which food is transferred from the main kitchen.

A fully equipped operating room is provided for the use of surgeons who patronize the hospital. In all cases requiring surgical treatment this is arranged for or carried out by the attending physician; not by the hospital staff. It is the policy of the hospital staff to confine itself strictly to the field of diagnosis, and, when a diagnosis has been completed, to return the patient to his physician with a report of findings and recommendations. If it is not convenient, or the attending physician wishes to further avail himself of the diagnostic facilities provided by the hospital (as, for instance, for histological examination of tissues at time of operation) he is at liberty to use the operating room facilities.

The hospital staff consists of a physician in charge, assistant physician, consultant in surgery, consultant in eye, ear, nose and throat, consultant in genito-urinary surgery, two trained technicians in the clinical laboratory, one technical assistant in the x-ray laboratory, a head nurse, and four nurses. All are full time except the consultants in surgery, eye, ear, nose and throat, and genito-prinary surgery, who are called in on special problems.

When a patient comes to the hospital he is usually accompanied by his attending physician, who wishes assistance in some particular problem, or the patient brings a note from his physician stating in a few words the patient's condition. After a short preliminary quizzing to determine the character of the case, the patient is put to bed and a four hour temperature, pulse, and respiration record is kept. In all instances a urine analy-

The beds are equipped with rubber-tired wheels, so that bed patients may easily be moved to this sun-parlor.

sis, blood count and Wassermann test are made, and a careful and complete history taken by the assistant physician. The assistant physician also makes a complete physical examination. The case is then gone over by the physician in charge, and a series of special examinations such as gastro-intestinal, x-ray, gastric analysis, stool examination, blood chemical analysis, basal metabolism determination, etc., outlined, depending upon the requirements of the case.

After these examinations have been completed and a conclusion arrived at, the patient is given a verbal report on his condition and a written report with all the findings and recommendations is sent to his attending physician.

The hospital has been in operation on this basis since July, 1919, and during the year 1920, 270 cases were examined (out-patients are not included). These cases are classified as follows: pulmonary, 58; cardiac, 28; gastro-intestinal, 86; genito-urinary, 28; nervous, 36; miscellaneous, 34.

The volume of work is increasing steadily, the territory served is widening and the physicians availing themselves of the facilities offered seem to be pleased with the service rendered to them and their patients.

The explanation offered is that this type of diagnostic center or hospital differs from the "group clinic" in being essentially unselfish in its aims—it does not attempt to take the patient away from the family doctor, it attempts to assist the doctor in rendering better service. Its purpose is to supplement the work of the practitioner, not to supplant it.

The idea is new and the plan not as yet completely worked out, but in so far as it has gone, it has been a success.

SAVING TIME IN THE HOSPITAL LAUNDRY*

By WALTER TRIMBLE, Chicago, Ill.

MOST employers and managers of working forces make the common mistake of assuming that because the workers are busily engaged they are losing no time. I have seen many busy forces of workers, however, who were each losing about fifteen minutes of every hour, although they were busy every minute.

Losing time through idleness is one thing and losing time from misdirected efforts and doing unnecessary work is quite another. Lots of time may be lost in your laundry department because the workers are required to do useless things, performing tasks that modern methods would eliminate altogether. In many a hospital laundry one may find in use old methods that should have been discarded long ago, to say nothing of obsolete, slow machinery.

In a certain hospital's laundry, the handling of nurses' aprons required eight steps in process, following the old method. However, when an efficiency man was called in, five of these steps were eliminated, and by making a few changes the labor cost on these pieces was reduced fifty per cent. The old process was as follows: (1) washing; (2) extracting the water; (3) starching in a starching machine; (4) extracting the starch; (5) drying in dryroom; (6) dampening for ironing; (7) rolling up to distribute the dampening; and (8) ironing by hand.

The old process was changed and reduced to three steps, as follows: (1) washing; (2) extracting water; (3) ironing on pressing machine.

Note that steps 3, 4, 5, 6 and 7 of the old process were omitted altogether. By the new method, the starching was done in the washing machine, after the last rinse, which eliminated step 3, starching in the starching machine, and step 4, extracting the starch. By the adoption of the cold-starching method and ironing the goods damp, direct from the extractor, steps 5, drying in the dryroom, 6, dampening for ironing, and 7, rolling up, were done away with.

The eighth step, ironing, was not altogether eliminated, but the time consumed in doing the work was reduced two-thirds. Instead of ironing the aprons by hand, they were ironed on pressing

VIEW IN IRONING DEPARTMENT

View of the large flat work ironer in the laundry of the Cherokee State Hospital, of Cherokee, Oklahoma. At the rear are the dryrooms, adjacent to which, at the left, is the starching department.

*This is the tenth of a series of articles by Mr. Trimble on the hospital laundry, which is appearing in The Modern Hospital.

machines, which do the work quite as well as it can be done by hand and much more rapidly.

Two operators on the pressing machines replaced six hand ironers. The omission of machine starching, drying in the dryroom, dampening and rolling enabled the manager of the laundry to dismiss two more girls from this work and put them at other tasks. Thus, by a few simple changes, the expense of six workers was saved.

Washroom Time Losses

Do not assume that because everything is humming all the time in your washroom no time is being lost. One modern rapid washing machine will do more work than two or even three ancient washers. Great progress has been made of late in the manufacture of washing equipment, and although the newer types of washers are very expensive, they soon save enough time and washroom supplies to pay for themslves. Besides this, they save expensive fabrics, for if the washing time is reduced, the wear and tear is lessened.

Slipping belts on the washers and extractors cause a great loss of time, and unless the manager is unusually alert he will overlook this, for it is a matter that is not easy to see. A slipping belt on a washing machine causes loss of time in two ways. First, it lengthens the time a load must be run, because the slipping belt reduces the machine's speed. Second, a slipping belt causes the goods in the machine to tangle, and this causes a loss of time in removing the pieces from the machine. In addition to this, there is a loss from goods being torn, for the average washman is apt to pull just a little too hard on the goods sometimes, and thus ruin many pieces.

A slipping belt on an extractor causes loss of time because the water comes out of the goods in proportion to the speed at which the basket is revolving. If the machine is running too slowly, on account of a slipping belt, it takes longer to extract the moisture to the point which is most economical for ironing. In the case of flat work, if the water is not properly extracted from the goods it causes loss of time on the ironing machine, and the same thing applies to pieces that are to be ironed on the pressing machine. Besides this, it is much more economical to remove moisture in the extractor than to evaporate it in the ironing process.

Much time is lost in many washrooms through the washmen having to go a long distance to the soap tank, to get soap solution. When powdered soap is used, the supply of soap, mixed with the proper proportion of soda, can be close at hand, thus saving many steps. In this connection I would caution the lay reader not to confuse powdered soap with domestic soap powder, which

GROUP OF BELT-DRIVEN MACHINES
This view shows the washroom of the Alexian Brothers' Hospital, of Chicago. Note the very large all-metal washing machine at the right. This hospital has 275 beds.

is quite a different thing, and not suitable for use in the power laundry. Powdered soap is sometimes called pulverized soap.

Small inlet and outlet pipes for water, which one often finds on old types of washing machines, cause a great loss of time, because the machine cannot be quickly emptied and filled. Admitting cold water into the washer and then heating it by means of steam is a time-wasting process, as it takes quite a while to bring water up to a germ-killing temperature. It is much better to have a supply of hot water in storage tanks and admit it for the hot baths.

Another great loss of time in the average washroom comes from the almost universal tendency to run washer loads and extractor loads too long a time. There should be in each washroom a complete formula for washing each class of goods, with the time of running each bath prescribed. Then there should be a clock, and it should be seen that the washmen go by it. Goods should be separated with regard to the dirtiness of the pieces, for it is foolish to run a load a long time because it happens to contain a few pieces that are harder to wash than the rest of the lot.

Load the washing machines to capacity, but do not overload them. Use the low-water system wherever it is practical, for it saves time in filling the machine with water and in discharging the water, and it also reduces the water consumption. Another advantage which the low-water system offers is that it effects economy in the use of soap and soda.

Finishing Department Hints

Much time may be saved, as I have already pointed out, by starching miscellaneous articles in the washing machine, after the last rinse, instead of using the old method of drying the arti-

AN IDEAL WASHROOM

This illustration shows the washroom of the laundry of the Cherokee State Hospital, of Cherokee, Oklahoma. Its equipment and arrangement are of the very best, and its lighting and ventilation cannot easily be excelled.

cles, starching them and then dampening them. If the amount of starch put into the washer is in proportion to the goods to be starched, there will be little starch lost in the extracting. Buy special ready-to-use starch for this purpose and thereby save the time that ordinarily is wasted in cooking and mixing it.

The starched pieces go directly from the extractor to the pressing machines, so be sure that they are free from excess moisture. With a complete equipment of pressing machines, the hand ironing department may be almost altogether eliminated. With a little touching up by hand now and then, even the most difficult articles may be ironed on the various presses. And if you are using the old-style, woman-killing body ironers, make haste to replace them with the more efficient and more humane presses.

The dryroom is now largely replaced by the drying tumbler, which is a great time-saving device. Underwear that is dried in a tumbler comes out softer than that which is ironed, and at the same time this method saves the time consumed in ironing the pieces. Bath towels and many other articles are finished best as well as most economically in the drying tumbler.

If you have much marking to do, by all means put in a marking machine, for plain marking saves time and confusion. Marking goods by hand should be as obsolete as writing letters by hand, but still some persist in doing so. See that your markers classify the goods properly for the washroom, thereby saving both time and trouble for that department.

Be sure that loads of goods do not "back track" and cross each other while they are going through the laundry. Arrange your plant so that things will keep going in one direction, and not be carried back and forth. Wherever it is possible, use conveyors of the endless-belt type, for they eliminate steps, and steps cost money. It may be a broad assertion, but I firmly believe that eight out of ten hospital laundries could, without spending a dollar for new equipment, reduce their productive payroll percentages twenty-five per cent.

ROCKEFELLER FOUNDATION REPORTS CONDITIONS IN CHINA

The second installment of the review of the work of the Rockefeller Foundation in 1920 tells of the medical school and hospital which the Foundation is building, equipping, and staffing in Peking, China. The enrollment for the year 1920-21 in the medical school will reach seventy-nine, says the review. It gives an idea of the power which the institution ought in time to exert in China, in the following:

"This Peking center ought in time to become not only an influence in North China and the Republic generally, but a rallying point for medical training and research for the entire Far East. It will maintain constant relations with Europe and North America. From time to time visiting professors from abroad will be in residence. To Peking will resort graduate students of ability and ambition. Practicing physicians and medical missionaries will find it a place of stimulation, refreshment, and congenial comradeship. Here, too, there is reason to believe, original contributions will be made to the world's knowledge of disease and its prevention. Already promising beginnings have been reported. The Peking Union Medical College aims at becoming a significant station in the world-wide system of medical education and research."

Of the conditions of hospitals and medicine in China, the review states:

"It is one thing to give Chinese men and women a modern medical training; quite another to provide conditions under which that training can be of largest service to Chinese communities. Unless the native physician can have access to laboratory and operating room, unless he can maintain professional and personal relations with competent and high-minded colleagues, unless he can count upon a certain confidence in Western methods among his fellow countrymen, the chances of permanent and worthy success are slight. Conservatism, faith in native medicine, family demands for quick commercial returns, absence of publicly enforced standards, temptation to compromise and quackery, beset the path of the Chinese doctor who undertakes to practice scientific medicine in his native land.

"The chief agency for helping the native practitioner is the Western type of hospital, which gives him additional education, offers him facilities, aids him in maintaining his ideals, and helps to disseminate in the community knowledge of the aims and methods of both curative and preventive medicine. In carrying out its China plans, therefore, the Rockefeller Foundation is aiding many strategically situated hospitals—for the most part under missionary auspices—to improve their buildings and equipment and to increase the number of their doctors and nurses. Thirty-one institutions of this kind were aided during 1920.

"In addition to maintaining the Peking center, the Foundation has, through the China Medical Board, made appropriations to a number of colleges in China for their pre-medical courses and has given aid to a medical school at Tsinanfu."

CARE OF RECORDS OF THE MASSACHUSETTS GENERAL HOSPITAL*

By GRACE WHITING MYERS, Librarian, Massachusetts General Hospital, Boston, Mass.

AS RECORDS are received, those of each service are clipped together by themselves and marked; i.e., East Surgical, West Surgical, etc., and at the end of a week, and before filing, the following routine inspection is done. First, each lot is arranged according to hospital number, and to each record is attached its admission slip now withdrawn from the file, and its name card also withdrawn from the temporary file. A clerk then goes over each history to verify the following points: Was this case admitted through the Emergency Ward; and if so, has the hour at which he was admitted been noted in the history? (It should be stated at the top of the first sheet of the history.) Was the patient transferred either from or to another service; and if so, has this fact been noted on the proper date? Was it a re-entry (this is stated on the admission slip); if so, has the reference to a former history been written in? If any of these data are lacking, they are looked up at this time and inscribed. Next: Was the patient referred to the house from the out-patient department; and if so, has the number of the out-patient record been affixed, and is it correct? For the purpose of accuracy on this point, a list of the names of patients thus admitted is sent in from the out-patient department to the record room under date of each day, with the out-patient number against each name. These numbers are written on respective name cards in form provided, and may be verified or supplied from there. (See Fig. 1, p. 110, August issue.)

Checking Lists

Next the records of a single service are taken, and with them the "lists." Suppose the East Medical records are examined first. The clerk turns back to the first page of the East Medical lists and runs her eye down the column until she comes to a name which has a "d" against it, and which has not had a pencil line drawn through it. All names so marked (with a "d") are cases which have been discharged during the past week. The first one found should correspond with the name and hospital number of the first record on the pile in front of her, these having been previously arranged according to that number, as stated above. She then makes sure that the number has been correctly copied, and that the diagnosis has been written in, in proper nomenclature, according to the classification of diseases adopted by this hospital, and that the proper classification number follows the diagnosis. Then turning over the sheets of the history, she sees that dates are carried forward from the bottom of one page to the top of the next, and that the history is complete with discharge written at the end. If the patient died and there was an autopsy, the number of the autopsy should be found on the chart sheet under the heading "Path. No." Otherwise, at the end of the history should be found the words "No autopsy." A list of the autopsies done during the week, with numbers attached, is sent in from the laboratory every Monday morning, that it may be in readiness for comparison or to supply omissions. If any serious error is discovered in the record, the house officer responsible is notified and he is expected to make corrections as soon as possible. If everything is found in order, a line is drawn through the name on the lists (see Fig. 3, p. 111, August issue) and the next "d" is sought out, and so on until all have been inspected. If it happens that a "d" is found and there is no record to correspond, a note is made of it and the house officer responsible is informed that such record is missing. The clerk in charge must not dismiss such matters from her mind until every record due has been received.

Pathological reports are sent in regularly from the laboratory and filed with respective records. In cases of autopsy, copies of anatomical diagnoses are also sent to the record room to be attached to their proper histories.

This inspection finished, the files of records are ready to be catalogued by diagnosis, and by operation, and to have the name cards completed with final information. (See Figs. 1 and 2, p. 110, August issue.)

The Operation Book

The operation book is a register of all operations done from day to day. Each day there is sent from the amphitheatre to the record room "operation slips," one for each operation done, these slips being verified by the senior house officer of respective services. They are copied into the operation book, which is columned and bears these headings: date, name, hospital number, service, operation, operator.

Bristol guides in three colors are used for headings; blue for main headings, salmon for subhead-

*This is the second and last installment of the article by Mrs. Myers on the care of records at the Massachusetts General Hospital, the first installment of which appeared in the August issue of THE MODERN HOSPITAL.

ings, and yellow for sub-headings in two positions where necessary, the end position being used for anatomical divisions, and the centre for degrees of disease, such as acute, chronic, etc. (See Fig. 4, p. 112, August issue.)

The catalogue includes the cards of both medical and surgical cases, and these are filed in ac-

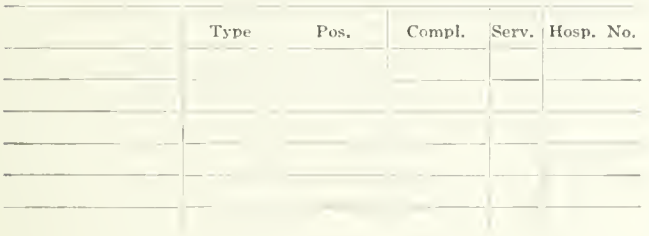


Fig. 5.

cordance with the classification compiled and adopted by the hospital in January, 1914. This classification comprises forty-one sections, under which all diseases liable to be met in a large general hospital in this locality are grouped. The classification is based upon the International Classification of Causes of Death, issued by the United States Government, in which each special group of diagnoses is numbered. In our own classification each diagnosis is represented by a number consisting of two figures: e.g., 1-35 is the number representing tuberculosis of joints, and any case of tuberculosis of any joint will have attached to it this number, both on the record (immediately following the diagnosis) and on the catalogue cards, at the top. The figure "1" indicates Section 1 of the Classification, and the figure "35" is the International group number. This is one of the steps towards hospital standardization, the International number being universal. The cards in this diagnosis catalogue are filed first, according to section; second, according to the alphabetic arrangement of diagnoses included in this section; and third, according to any further subdivision necessary, such as anatomical region, or by specific terms (acute, chronic, etc.); e.g., to take the same illustration used above, tuberculosis of the knee. The blue (or main) guide in the catalogue is marked "Section 1 Specific Infectious Diseases and General Diseases." Back of the section guide, a salmon left-hand guide, in its proper alphabetic position, is marked "tuberculosis." Back of this guide are yellow right-end guides bearing the names of the various anatomical regions arranged alphabetically: as ankle, elbow, intestines, knee, larynx, etc. Back of the guide marked "Knee" will be found cards cataloguing all such cases. The cards used for cataloguing are buff and white, buff being used for male cases, and white for female, and they are all arranged under their various headings in chronological order, without reference to sex, name, or any other condition.

Fig. 5 shows the card used for cataloguing the primary disease, and Fig. 6 the complications. Each is a cross reference to the other. Eight cases of the same diagnosis may be catalogued on one card. In the upper right-hand corner is written the year; in the center, close to top edge, the classification number; and in the left-hand corner, the serial number of a group of cards bearing the same diagnosis. On top line, at extreme left is written the diagnosis, and following it the anatomical region affected (where such is called for). Below, the first column contains names (surname always being written first) and other columns are filled in as indicated. Death is recorded by underlining whatever is written in the last two columns. Fig. 7 shows the card used for cataloguing operations. Data recorded above the top line is exactly the same as above described for diagnosis cards, and below are recorded the various operations performed upon cases bearing the same diagnosis.

Advantages of the Classification

The use of the classification number has several advantages: as a means towards hospital standardization, as mentioned above; as insuring the same nomenclature being used by everyone authorized to make diagnoses, i.e., he must find the right number and use the diagnosis as printed against this number. For instance, cholelithiasis must be written cholelithiasis, not gall stones, nor biliary calculi. And it must be catalogued just as carefully, and if errors are discovered they must at this time be corrected. The numbers also serve as a filing guide. The cards for the current year are filed in a separate catalogue for use in compiling the annual report of statistics, which may be copied directly from the cards just as they stand. After this report is made, the year's cards are transferred to the permanent catalogue, being filed as explained above.

No record is ever loaned to be taken outside the hospital except in answer to a court summons, in which case it is sent in the care of a trusted messenger who must keep it in his own hands and return it safely. In these instances the borrowing slip is signed by the resident physician or one of his assistants. It is not allowable for any person outside the hospital staff to consult records except by special permission from the resident physician, in which case the person so permitted is given a note to this effect which he must present to the record librarian. Lawyers are not allowed access to the records. They may have abstracts by making written request, and stating for what purpose such abstract is to be used. An in-

dividual who has been a patient may make personal request for a complete copy of his own record, which may also be certified if desired. The hospital requires payment for all such work. Information is furnished free to family physicians of patients, and to other hospitals requiring it.

In cataloguing a surgical case which has a pathological report attached, in case of any difference between the clinical diagnosis given on the chart and the pathological report, the latter is always followed as the correct diagnosis. Also, in cases which have come to autopsy, the anatomical diagnosis is followed by the cataloguer rather than the clinical one. Every effort is made to have the catalogues as accurately written as possible, and in a perfectly plain, legible hand, preferably vertical, as this occupies less room.

The records, each service always kept separate, are temporarily filed (i.e., until ready to be bound), in Shannon Binding Cases, suitably inscribed upon the back. Records are filed in strict numerical succession, reading from the bottom of the case up, bringing the highest numbers (or the latest cases) on top. Numbered guides of manila cardboard are placed between every hundred records,—not literally one hundred records, but whenever the unit of hundreds changes; e.g., 176100, 176200, 176300, etc.—affording facility in turning to any individual case. Great care must be taken in this filing that every record is placed exactly where it belongs, and no clerk is allowed to do this alone until she has been thoroughly drilled and watched, and no one except those belonging to the regular force is allowed to remove or replace one.

Binding the Records

The preparation for binding occupies half the time of one clerk. Volumes contain about three hundred pages. This varies a little according to the date reached when three hundred pages have been counted off. For instance, suppose that the three hundredth page completed a record dated the fifteenth of a month, and there were two or three more records bearing the same date; all the records of the fifteenth would be included in one volume rather than separate them, even though the number of pages might run as high as 325 or 330. The same license is granted when approaching the very end of a month or a year. It is better to make good divisions than to adhere to a hard and fast rule.

The first step towards binding is to take the first box in the file of a service, say the West Surgical, which will contain the records immediately following those of the last binding, and compare these records with the West Surgical "list." As soon as records are bound, a blue line is drawn vertically through a list down to the number which will be first in the next binding. Beginning, therefore, with this number, it must be assured that every name on the list has its corresponding record in the file and in its proper place, checking off with a red pencil at the side of the list as the examination proceeds. This checking goes on until a number is reached which has not had a pencil line drawn through it, this meaning, of course, that the patient is still in the hospital. Up to this point records are now lifted from the boxes and placed in one pile upside down, as the earliest date is at the bottom. Now the sheets are counted off up to 150 which will constitute a volume of 300 pages. If a condition regarding date is noticed, at the end of this 150 sheets, such as has been mentioned above, a few more sheets are taken off in order to make a wise division between volumes. The order of records is then reversed in order to bring the earliest date first in the volume. Then these are strapped together with rubber bands and laid on one side. The same method is pursued until the bottom of the pile is reached. If an odd number of sheets is found in the last counting, i.e., not enough to make a volume, such sheets are returned to the case to wait until the next binding. In order that the

Complication Card.

Type	Pos.	Prim. Dis.	Serv.	Hosp. No.

Fig. 6.

whereabouts of records may always be known to those wishing to consult them, a card marked "Taken out for Binding," and giving below the inclusive numbers of such records, is attached to the back of the first box containing the unbound records of the service. During the process of preparation, these records may be consulted whenever necessary. They are at the bindery but three days, and when they are returned the above mentioned card is removed from the back of the box. Now the volume is ready to be paged, which is done with a numbering stamp. It is then ready to index.

Double Index Made

A double index is made, one by hospital number and one by date and name; and these are typewritten. The former is a two-column list occupying one page, the hospital numbers being given in strict numerical succession with reference to the page upon which each may be found. The other

index has the following headings: date (of admission), name (the surname being always given first), page, and diagnosis.

When the indexing is finished a title-page is printed, giving the service to which this volume belongs, its number, the dates covered, the name of the surgeon on duty, the name of the assistant surgeon, the name of the house surgeon, and below these names a heading "House Officers," where such are required to sign their names. This list of house officers includes those who were

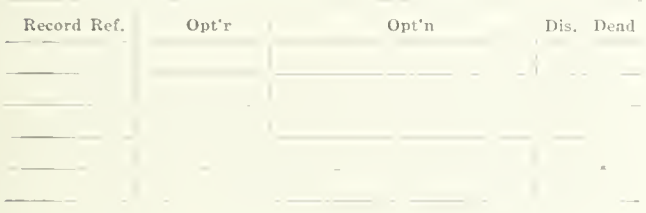


Fig. 7.

on duty between the dates covered by this volume, and were responsible for these particular records.

Last of all a pattern is made for the binder, showing him exactly what is to be printed on the back of the volume, and where it is to be printed. These items are as follows: At the top, the year; below this a large letter, either "E" or "W," indicating East or West service; below the letter the abbreviation "Med." or "Surg."; then inclusive hospital numbers; and at the bottom inclusive dates. It is important in every instance that this pattern should be made, for if left to the binder serious errors would be liable to occur. From twelve to fifteen volumes at a time are prepared, and are usually returned from the bindery in three days' time, it being understood that this is "rush work." The binding is of boards covered with a light gray canvas, and the printing is in plain type, black. In shelving, each service is kept in a section by itself in the record vault. Account is kept by the indexer of all volumes sent to the bindery, and when they are returned it is her duty to immediately examine them and be sure that the "backs" are correct.

The indexer must see now that the house officers who were on duty between the dates covered by a volume sign their names upon the title-page, and to this end she writes the initials in pencil against the line where each is to sign, and then sends to each a note giving the numbers of the new volumes which are ready for him.

One year from the date of a patient's discharge, a "year-ago" letter, filled in with proper superscription, and signed by the resident physician, is sent out. This letter requests the patient, if possible, to return to the hospital for examination, in order to ascertain his exact condition at this time. In case it is impossible for him to return, he is asked to write and state as definitely as possible what his condition has been during the past year. If he responds in person, a physical examination is made, and notes written by the examiner at the end of the patient's hospital record, this record having been sent (upon call) to the examining room. If the response comes by letter, an abstract of important points is made at the end of the record, under date of the letter. If no response is received, and the case is considered of sufficient importance to follow further, a letter is sent to the friend whose name and address appear upon the name card (Fig. 1), or a letter is sent to the patient's family physician, whose name also appears upon the name card. If these attempts fail, city and town clerks are asked to search their records, information often being obtained in this way.

GOVERNOR OF NEW YORK STATE VISITS HOSPITALS

Governor Nathan M. Miller, of New York State, has expressed himself as being very well pleased with the conditions which he found on visiting the state hospitals recently. His statements in regard to the care of ex-service men should be of especial interest.

"As for the ex-service men, regarding the treatment of whom the State has been attacked by members of the American Legion, they are practically all in a class which is capable of cure. For this class—about 20 per cent of our hospital population, including both civil and military patients—there is special treatment, special attention and most modern medical and therapeutical appliances, special diet and a very great work in vocational training.

* * *

"I am especially interested now in the problem of the industries carried on in State institutions. Clothing, shoes, printing and farm work are among the occupations of the patients of the State hospitals. They also do a great deal of their own repair and construction work. They have in the State hospital at Utica a printing shop where they print hospital reports and blanks and things of that kind.

* * *

"I feel very strongly that the charges made against the State by the Legion are based either upon insufficient facts or upon misstatements, and I do not think the ex-service men have their cause advanced by any such hostile propaganda. One of many phases of this propaganda is contained in a transcript of what Dr. Salmon said to the Congressional committee. He is quoted as having said: 'I want to call to the attention of the committee the fact that nearly four hundred ex-soldiers committed suicide in the State of New York in the year ending June 30, 1921.'

"That was a statement that was scattered broadcast, and when I saw I was alarmed. Of course I did not believe it. I found at once it was not true. Now Dr. Salmon, I see, has corrected it by a letter which nobody reads.

"The second charge of the Legion is a very serious one: that the State is profiteering on the care of mentally afflicted ex-service men.' I am asked to investigate this charge. I do not need to investigate it. I know what the facts are. The statement is made upon insufficient facts, and it is absolutely untrue."

WEST BADEN AS IT IS TODAY

THE story of West Baden Springs, the big health resort, which has been selected for the meeting of the American Hospital Association in September, is the story of a century of progress. From a beginning that was crude, unpretentious, unattractive even, in many respects, the cycle of a hundred years shows brilliant achievement and well-deserved fame. The history of the development of any great institution is always one of keen interest, but in the history of West Baden much may be added to the mere tracing of business acumen and financial gain. From a two room log cabin to a magnificent structure, unsurpassed in architectural beauty, is a far step even for a hotel, but it is the touches of romance, the struggle against adverse natural conditions, the bitter opposition of unwarranted prejudice, physical losses that would have daunted even the bravest, and the unconquerable ambition to occupy a niche in constructive ingenuity never before deemed possible, that give to this story its greatest charm.

Known in earliest days as the Mile Lick, this place was patronized by pioneer settlers, who came in wagons and prairie schooners to drink of the waters and to fill great jugs to carry home. Meals were served these first patrons in a log cabin nearby, but they had to furnish their own sleeping quarters. There were at that time five mineral springs here and thirteen in all, in the valley. A big fresh water spring flowed from one of the cliffs overlooking the valley, and this was later used for the hotel supply.

Sprudel Spring Number Seven, the largest spring at West Baden, the waters of which closely resemble the famous Carlsbad waters of Europe.

In 1846, Dr. John A. Lane, a far-sighted physician, who was traveling through this country, saw the possibilities of this tract and acquired it. He first built a saw mill, sawed and seasoned the lumber and then built a good frame hotel. He invested all his capital and borrowed $1,800, and everyone laughed at him for his foolish venture. The springs were valuable, to be sure, but much of the year all the ground was inundated and the springs could only be reached by going on stilts. Nevertheless he succeeded, and during his tenure, records show that more than 7,000 people visited the place every year coming mostly from Indiana, Illinois, Kentucky, and Missouri.

With a few years intermission he was in charge until 1883, when the site was taken over by Dr. Braden, and a group of Orange County business men and bankers. Financially this venture was not as successful as it had been, and gradually the stock was acquired by Colonel Lee W. Sinclair, a successful manufacturer, who sacrificed large business interests in other lines for the successful working out of his theory that this place, properly equipped, could be made one of the leading health resorts of the world.

Mr. Sinclair at once set about enlarging the hotel, building walks and drives, and beautifying and grading the grounds. With surroundings that were extremely picturesque, low ranges of hills, winding valleys and great forest trees, the place soon became known as one of the beauty spots of Hoosierdom. With transportation facilities improved, and the hotel better equipped, the resort was kept open the year around instead of for the summer only, as heretofore.

Although now Sprudel Spring, the famous Number Seven, is by far the best known of all West Baden's waters, this was not found until 1892. Traditions abounded of a wonderful "gusher" that had been known in early days, which, through spite and jealousy, had been filled in. Tracing a faint line indicative of mineral deposits, this abundant flow of health giving waters was found and speedily utilized. The legend regarding the spring was verified, that is, that a tree had been felled into the spring itself and the drain from it, and heaped over with soil, in the discovery of masses of petrified wood when the source was unearthed. So constant and so free is the flow of this spring that, since its discovery, only two of the

other springs, Apollo and Hygiea, are used.

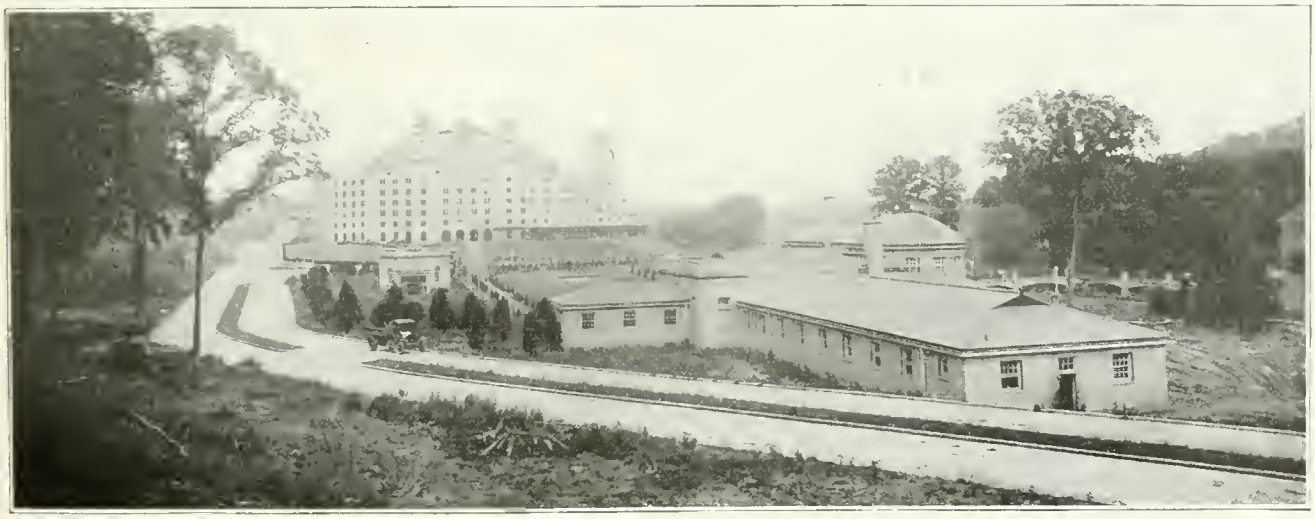
The resort continued to grow in size, in beauty of environment, and in popularity until June 14, 1901, and then, in a few hours time, everything was wiped out by fire. While the embers were still smouldering the owner declared that the hotel should be rebuilt, and that it would be a structure that fire could not destroy.

A few years after the new hotel was completed, overwhelming demands seemed to make the erection of a hospital, diet kitchen, and dining rooms, and other smaller buildings imperative, and these were built of wood. For a few years only they fulfilled their mission, and then fire again swept them all away.

Although the hotel building, dining room, kitchens, bath department, garage, natatorium, and other fireproof structures connecting, came through the latest disaster unharmed, the irreparable loss was felt in the loss of the magnificent trees and the destruction of the natural beauty of the grounds. Formal landscape gardening has been called in to make good the damage done, and today no trace remains of the havoc that was wrought.

The comprehensive plan for new spring pavilions, Italian gardens, solarium, walks, drives, and the completion of the eighteen hole golf course was only fairly well begun, when the war came and West Baden responded to the call for help for the sick and wounded soldier lads. Construction in all lines was halted and every facility surrendered to hospital service as long as the hotel was needed to play its part in military affairs. It was turned back to the West Baden Springs Company at a time when labor and material for constructive work were most difficult to obtain, but notwithstanding these handicaps, the whole plan of reconstruction has been pushed through as rapidly as possible. Mr. Sinclair died just prior to the outbreak of the war and since his death the responsibility for the management of the big hotel and estate, and the improvements made, has been carried by Mr. Charles Rexford, who for some years was associated with Mr. Sinclair, and who, upon the reorganization of the West Baden Springs Company was made its president.

The first work undertaken under the supervision of Mr. Rexford was the redecoration of the great inner court of the hotel, now known as the Pompeian Room, the vast space that is to be utilized for the convention of the American Hospital Association. With skilled artists in command, beauty has indeed been created here. Always an imposing court, its proportions, in the newer guise, seem almost doubled. The cement floor of other days has given way to a pavement of Pompeian marble mosaics, over twelve million being required to work out the chaste design of intricate bands and frets. The facade of bricks has been replaced with a wainscoting of Hauteville marble, twelve feet high. The decorative scheme throughout is Pompeian, Caen stone buff, Pompeian green, Pompeian red, dull blue and a hint of gold being the colors utilized, a combination which suits the huge rotunda as no other could have done. The huge dome has been transformed with its harmony of decoration and the magnificent electrolier which hides the hub. The twenty-four massive columns have been brought out in remarkable relief, with as cunning a setting as that which enhances the beauty of a gem. Four superb statues in Caen stone, after originals by Scofas, occupy the four principal quarter sections of the atrium. They are mounted on onyx pedestals, and are complemented by eight large and eight smaller urns of the same material, filled with tropical plants, ferns, and palms. Marble benches, especially designed chairs and settees, and over all a wonderful lighting system that en-



General view of West Baden Springs Hotel, West Baden, Ind.

hances the rich beauty beneath, combine to make this perhaps the loveliest as well as the largest rotunda in the world.

It is, first of all, this magnificent inner court, spanned by the wonderful dome, that has given the hotel its world-wide fame as a triumph in architecture. The diameter is two hundred feet, and the height from the floor to the dome is one hundred and thirty feet. The diameter of the dome in the capital at Washington is one hundred and twenty-eight feet, and the great St. Peters church dome is one hundred and sixty feet in diameter, or forty feet less than the dome of West Baden. There are 60,000 square feet of tiling in the dome, and the glass, if laid end to end, would make a walk sixteen inches wide, two miles and three quarters in length. The floor space of the atrium is 62,832 square feet, and the air space is 2,730,000 cubic feet. There are 120.5 tons of steel in the hub and ribs of the dome, the expansion and contraction of the metal being taken care of by means of rollers which rest on the supporting columns.

The rooms are arranged in a double tier surrounding this great court, connected by a spacious corridor. Half of the rooms look down into the court and half out upon the grounds. The rooms are commodious, modernly equipped, and beautifully furnished. Fifteen acres of floor space give some conception of its size.

Its vast extent, including the great court as a center where thousands, may, if necessary, assemble, is fast bringing the resort into popularity for conventions and general meetings. There are two large convention halls, one on the first and one on the third floor, directors' rooms, and a motion picture theater. Dining room facilities are ample and sleeping apartments care for hundreds of guests. In this day, when a better understanding of mutual problems, a closer comradeship and spirit of "get-together" is so essential in all organizations, it means much to hold an annual meeting where members can live, work and play under the same roof. Plenty of opportunity is afforded for play. A splendid golf course on the crest of the hills on the hotel grounds, good saddle horses, and a hundred miles of bridle trails, trap-shooting, tennis, baseball, and field sports lend their fascination to life out of doors, while pool, billiards, delightful musical programs and dancing parties add their charm to the hours spent within.

It is only for a period of a few weeks during the year, however, that the resort can be given over to large assemblies, and that is just prior to or just following the regular seasons. For the major part of the year the full capacity of the hotel is needed for the use of health and pleasure seekers, who find in the complete change of scenery, the wholesome life, the opportunity for rest and relaxation, and the regulated use of the waters and baths, the satisfaction of their greatest needs in the process of keeping physically fit.

JOHNS HOPKINS HOSPITAL REGULATES FEES

In view of the wide-spread publicity, much of it inaccurate, which has been given to the fact that the authorities of the Johns Hopkins Hospital had adopted certain resolutions regulating fees which would be permitted for services rendered to patients treated in the hospital, THE MODERN HOSPITAL takes this occasion to publish in full the resolution which was passed by the board of trustees of the Johns Hopkins Hospital on June 14, 1921, on the recommendation of the medical board.

Whereas, The trustees of the Johns Hopkins Hospital desire that all patients may leave the hospital feeling that they have received not only proper professional, nursing, and administrative service, but also that they have been dealt with fairly in every particular, including charges for medical and surgical service, and

Whereas, The trustees believe that the members of the staff likewise desire this result and will continue to cooperate in carrying out the policy of the hospital as considered for the best interest of the patients and the hospital, therefore

Be It Resolved, That the following regulations be adopted:

1. That members of the staff shall bring promptly to the attention of the director of the hospital any conditions or circumstances which they feel justify criticism and should be corrected, also any just complaints uttered by their patients or the friends and relatives of patients, applying either to the professional service or to the management.

2. That all fees to be charged for services rendered any patients in the private rooms of the hospital shall be subject to the jurisdiction of the committee on fees and shall in no case exceed the amounts stated below, except where the consent of said committee shall have been obtained, it being understood, however, that all fees charged shall in no case impose a hardship upon those responsible for their payment and shall be arranged in advance of admission (wherever possible, or as soon thereafter as possible.

A—Professional service by physicians $35.00 per week, which includes at least three visits by the patient's physician.

B—Consultation fees $25.00.

C—Maximum fee for major operation $1,000.

D—No consultation fee shall be charged patients entering the public wards, when the examination has been made anywhere in the hospital.

3. That not more than ten rooms shall be at the disposal of any one member of the staff at one time, if the private rooms are in demand by other members of the staff having the same privilege.

FUND FOR BROAD STREET HOSPITAL PROGRESSES

The Downtown Hospital Association of New York City, reports that the first week of the drive for funds which is being made for the new Broad Street Hospital brought the total to $256,000. An anonymous donor gave on the last day a gift of $100,000 bringing the total up to this figure.

DEVELOPMENT PLAN FOR THE UNITED HOSPITAL, PORT CHESTER, N. Y.

By HOBART B. UPJOHN, Architect, New York City

IN VIEWING the problem of designing a hospital, among the many varied questions that come up is the matter of finish of woodwork, walls, and floor. We are just emerging from a phase where the demand has been for hard finished floors, and the walls and trim of a dead white. Many doctors have come to the realization that this color, especially in an operating room, is very trying to the eyes. If then, the use of dead white enamel on the walls is trying to the eyes of a doctor, it must be as trying to the eyes of a patient, who has constantly to look at it.

It has come to be a well established fact that the mental condition of the patient is one of the most vital if not the most vital factor in the curing of many diseases. This is borne out by the use of bread pills and the decreasing use of medicines in many cases. Make the patient as comfortable as possible, assist the body to do its own curing, and there will be few cases to worry about.

This is largely true of medical cases, but it applies even more strongly to surgical cases, where there may be little bodily ailment, and making the patient comfortable is the main object.

The ideal for the hospital, home, or any piece of successful architecture is that its design will arouse and hold one's interest. A hospital, just as much as a home, should hold out a welcome when you enter. The over-accent of the desk in the hall, the usual narrow door into a stiff reception room, the absence of any comfort or color, and the presence of wheel chairs and stretchers give the patient a hopeless feeling.

The hospital is a place to get well in and not a place to be sick in. It should be a place of joy, not sorrow, and the conveyance of this idea to every patient is, in my opinion, of the most vital importance.

Some years ago I had the pleasure of going through the Brady Memorial in connection with the Johns Hopkins Hospital, where a delightful color scheme and treatment has been adopted by the architect, Mr. Grosvenor Atterbury. Here the wards are so divided that each patient has an alcove of his own, with furniture to match the woodwork.

With these ideas in mind, the writer developed the plans for the enlargement of the United Hospital in Port Chester, N. Y.

The problem was a difficult one. The original scheme had been to build the group in the form of a "U," but the connecting link of the "U" had been designed as a nurses' home, the halls being too narrow to be converted into a central link, connecting the two wings. When the question was brought up to our hospital advisor, Dr. Woodbury, he immediately pointed out the obvious fact that to add another wing under these conditions was practically to build two distinct hospitals and double the overhead. This plan was therefore abandoned and other means to relieve the situation were sought.

There was no adequate entrance from the court

The United Hospital, Port Chester, N. Y.

The working offices of the memorial wing.

The reception hall in the memorial wing.

except through a rather crude basement hall. As the heating apparatus was located on this floor and under the head nurse's rooms, it was deemed advisable that it should be placed in a separate building and many conveniences added and inconveniences eliminated.

To meet the situation, the architect suggested two wings connected to the end wings of the old building. Between these wings connecting them with the main building was designed a one story building or terrace, which housed the administration quarters, parlors, doctor's rooms, and x-ray department. The roof formed a terrace for convalescent patients.

By the adoption of this plan, proper orientation was secured, advantage was taken of the conditions of the lot, and the plan was made to conform to the crest of the hill.

It will be observed that the administration terrace is placed in the most strategic position, all parts of the building being easily available.

The hall is opened up and there is a large reception room to the right as one enters. It is comfortably furnished in color, with soft chintzes on the windows, and gives a feeling of hospitality to those entering.

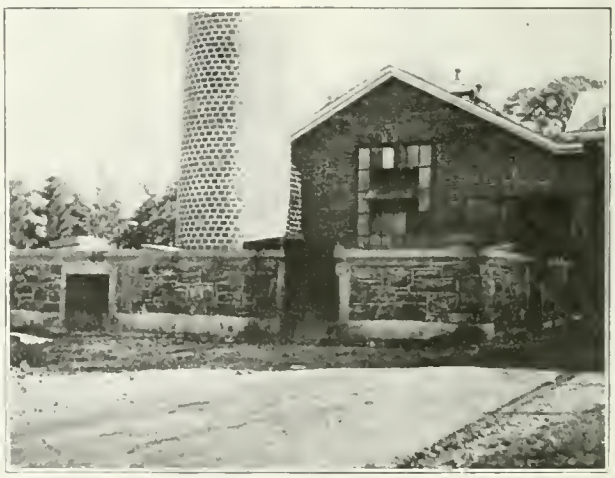
In the center of the hall is a large skylight under which a mass of palms adds to the attractiveness of the scene, and one is impressed immediately on entering with the fact that this is not a place to be sick in, but a good place to come to get well.

An x-ray room with a developing room properly protected, a doctor's room, a private reception room or parlor, and a large kitchen store room, complete the floor space in this wing.

The main wing which lies to the north of the terrace, is devoted mainly to housing private patients. In the basement, a story entirely out of ground, are several semi-private rooms, accommodating two, three, and four patients each.

Above this are two floors divided into private rooms and baths, reached by means of an automatic electric elevator or from the corresponding hall in the main building. The top floor furnishes accommodations for the additional help which is required in the enlarged building.

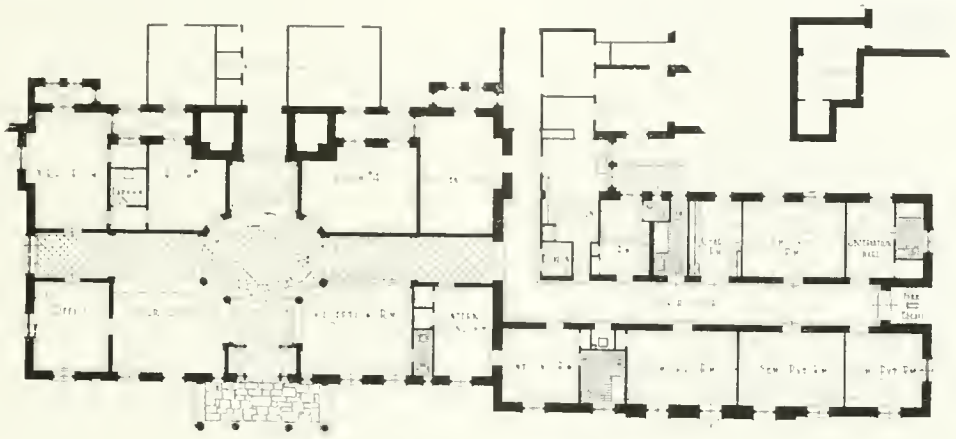
A general view of the addition of the memorial wing of the hospital.



The power house of the memorial wing.

Each floor is connected directly with the main building but all noise is cut off by double doors.

The main kitchen in the basement is connected to the diet kitchen on each floor by means of an adequate dumbwaiter system.



First floor plan, Memorial Wing, United Hospital.

Perhaps one of the unique features is the arrangement of the chart room. It is located off the hall of each floor in an alcove, the purpose being to keep the nurse in charge in constant supervision of the floor, but to avoid any interference with the hall space by placing furniture there.

At the rear of the hospital a new power house is located, the size being planned for the future growth of the building. The chimney is eighty-five feet high, and will take care of the future enlargement of the plant. In the engine room is located the hot water heating system, the feed pumps, the circulating pumps, etc.

The coal is stored under the driveway, so that delivery of coal into the bin is accomplished as conveniently as possible, and the boiler room is so arranged that the coal is within easy distance of the boiler front.

The boiler room is connected with the main building by means of a pipe tunnel, so that at all times the piping of the entire system is subject to inspection.

One interesting feature of the plans is that the building of the separate boiler house was found to be only slightly more expensive than to excavate sufficient room under one of the wings to house the plant. By the adoption of this plan sufficient boiler capacity was obtained to efficiently take care of the steam heating, sterilizing, hot water supply, etc.

Second floor plan, Memorial Wing, United Hospital.

The Surgeon-General of the Navy has ordered the United States naval hospital at Yokohama, Japan, to be closed because the demand for hospital facilities in Japan has decreased of recent years, this institution is considered too expensive to maintain.

SWEET BILL BECOMES LAW

The Sweet bill, which provides for the establishment of a Veterans' Bureau in the Treasury Department, consolidating agencies of the United States Public Health Service, dealing with former service men, the War Risk Insurance Bureau, and the Vocational Rehabilitation Board, which was passed by the House in June, was passed by the Senate on July 20. It was signed by the President August 9, and ends a long struggle to place the various activities relating to the care of ex-service men, including necessary hospital care and treatment, under a single bureau.

The MODERN HOSPITAL

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CONVENTION TO DEAL WITH VITAL PROBLEMS

WHEN you come to West Baden to the Annual Convention of the American Hospital Association, you will not be called upon to sit quietly for four days and listen, without a break, to formal paper after formal paper. On the contrary, there will be abundant opportunity for informal discussion, with relatively few papers. Delegates to recent conventions recall the keen interest aroused by the round table discussions led by Mr. Asa S. Bacon. This year, however, there will be not one but six round tables on such fundamental subjects as service to the patient, dispensaries, and construction, administrative, and departmental problems. For their success, these round tables will depend very largely upon members of the Association, and they are urged to come prepared to submit problems that have baffled solution when tackled single handed. The discussions will be broad in their scope, but those who have been chosen to conduct them have been instructed to hold speakers rigidly to the points under discussion.

Positive progress toward solving some of the most vexatious and mooted questions which the hospital field presents, will no doubt be made in the reports of the special committees that have been hard at work on them during the past year. An entire evening will be given to these reports. They will deal with hospital forms and record keeping, flooring materials best suited for use in different departments of the hospitals, the relation that exists between hospitals and the states and cities in which they are located, the subsidizing of hospitals by the state, and the education of hospital social service workers. These reports will not only be rich in information, but will serve as a basis for sadly needed standardization in certain lines of hospital procedure.

Some interesting and timely subjects will be presented in the few formal papers. Dr. Haven Emerson will demonstrate how hospital records can contribute to health protection. Dr. Charles S. Woods of Indianapolis, Ind., and Dr. F. R. Nuzum of Santa Barbara, Cal., will indicate how good professional work can be developed in the hospital. Mr. Guy J. Clark of Cleveland, O., will speak on the timely subject of cooperative purchasing by hospitals, and the editor of THE MODERN HOSPITAL will place before the convention some illuminating information about the salaries of hospital superintendents.

The convention will also be marked by addresses by Mr. John C. Bowman, who, as most of our readers know, is now chancellor of the University of Pittsburgh, and by Dr. Haven Emerson, medical adviser and assistant director, Bureau of War Risk Insurance, Washington, D. C.

THE EPIDEMIOLOGY OF GOLF

GOLF (O. D. Kolf, a club) is a chronic, incurable disease occurring in all climates, at all ages, but most often among males in the fourth decade, and characterized by alternate periods of mental elevation and depression. The disease is ushered in by an acute myalgia of the muscles of the trunk extremities and delusions of wealth as evidenced by the miscellaneous purchase of bags, clubs, and balls. In the initial stages there is a marked change in the vocabulary and apparently meaningless words such as tee, lie, whiff and dub are used. In the chronic stage there is a settled and prevailing profanity. Physically, the disease is characterized by the loss of the equatorial mid-riff, general hardening of the musculature, tanning of the face and forearms, and general increase in the coordination of brain, eye, and muscle. A marked irritability alternated by periods of beatitude is to be noted in cases of long standing. The disease is most violent on Sundays, holidays, and convention periods. Although associated with insect life, golf is spread by intimate contact with persons in the chronic stage. A sub-variant, known as chin golf, is recognized.

Golf appears to have had its birthplace in Holland and numerous paintings depicting its victims putting at a stake set in the ice are still extant. It is believed that these represent merely the hibernating form of the malady. The stake is still used in different form.

Introduced in Scotland by sailing vessels, it spread rapidly in spite of may legislative acts and formed there an endemic focus, which has never been eradicated. Thence it spread into England, forming several virulent subfoci, one of the most active still remaining at Blackheath, also famous for its highwaymen. The connection between the two has never been established. Delegates to the forthcoming convention of the American Hospital Association are warned that West Baden is one of the most virulent subfoci in this country.

Modern transportation has facilitated the distribution of golf round the world, at first gaining entrance to the larger centers, whence it has traveled out to the more sparsely settled districts. Thus from an urban disease it has gradually become metamorphosed into an affliction of town and country alike. This spread cannot but be viewed with other than alarm by those engaged in the public health and hospital fields. A disease which may attack both sexes and all ages, which reduces the morbidity and mortality rates, which promotes longevity and delays senility, strikes at the taproots of the hospital and health worker's livelihood. Worst of all, all repressive measures seem futile. The clergy has preached against it as an enemy of church attendance; business men have realized that they must either give up golf or business and have sacrificed the latter, poets have raved over the fact that nothing will rhyme with it; yet it has crept forward, insidiously attacking all with whom it comes into contact. One-armed men have succumbed to it; advertisements for artificial limbs now show a central figure just about to smite or dub his drive; and as for the collar and shaving soap ads, what would they be without golf? Women no longer exercise with a crochet needle and a box of chocolates, instead they wield a mashie and abuse the careless caddy. Yes, golf has come to stay, and relief can be gained only by submitting to the inevitable infection.

WHAT IS A HOSPITAL FOR?

RECENT numbers of THE MODERN HOSPITAL have contained discussions between Doctor Warner of the American Hospital Association and Reverend Father Straub, administrator of St. John's Hospital which is located in Springfield, Ill., and others, on the general proposition, "What is the function of a hospital?"

Father Straub took the position that the hospital should furnish the equipment, the nursing service, the food, and the material and personal comforts required in the treatment of a patient. Beyond that it should not go.

About the time this discussion was at its height, the Illinois State Association of Osteopaths held their annual convention in Springfield, the home of Father Straub and his great hospital.

The osteopaths arranged with a number of their patients for surgical and for eye, ear, nose, and throat clinics at St. John's Hospital during the convention. Operating and dispensary rooms were engaged, and the clinics were liberally advertised.

Thereupon, the leaders in the local medical society protested against the invasion of the osteopaths, and made their point so strong that the osteopaths, not desiring to embarrass the management of the hospital, withdrew as gracefully as possible.

Because local osteopaths have been permitted to practice in St. John's when their patients asked for them, there has been agitation for the building of a new hospital in Springfield, which should be open only to the recognized schools in medicine.

This incident is not referred to for the purpose of debating the action of the old practitioners or of Father Schaub, but simply to show that often the view expressed by Father Schaub, as to the function of the hospital, is not practical. The fact that the regular schools will not practice in a hospital which admits the unrecognized is not a theory but a condition to be met when we discuss what function the general hospital should perform in the community.

WOMEN IN CHARGE OF MALE INSANE

A WOMAN recently completed seven years continuous service in charge of a 150-bed ward for male patients in one of the Illinois state hospitals. She weighs 120 pounds, is the mother of two boys whom she is supporting, and a graduate of the hospital's training school.

Her ward is semi-hospital; it might be called an infirmary. On one floor the men are ambulant; the second floor is given over to paretics, in every stage of the disease, and old men.

All the nurses and attendants are women. Able bodied and trustworthy male patients from other wards of the institution do the heavier housework.

Before this woman entered the ward it was in charge of men, a shifting, shiftless lot of state hospital attendants, who communicated to their patients their own worthlessness, restlessness, indifference, and brutality.

The ward is a building with a basement in which there is a dining room for ambulatory men. Patients on the second floor are all tray fed. Such a condition of affairs made for dirt, vermin and filth and all of these were present in large quantities. Worse than this was the brutality practiced upon the disturbed paretics and terminal, restless old men. The ward was for years the scandal of the institution. Broken ribs, blackened eyes and even violent death itself called for continuous investigation. A murder trial grew out of the death of one old man but the accused was acquitted.

Seven years have now passed without a broken bone or serious injury. Women's hands have cleaned and cleansed it of dirt and vermin. Beds and patients are always clean. The institution odor has disappeared. There is no restraint of any kind. The calmness and poise of good nursing, the absence of friction among employees, the elimination of drinking, and the introduction of trained people in charge have rendered the ward a fit place for the unfortunates who people it. After her seven years of service this woman says, "I would seriously object to a transfer to any other ward and especially to a female ward."

It was the success of the experiment with women in this ward that led to the introduction of women nurses and attendants upon practically all male wards in the Illinois state hospitals. The freedom of these institutions from scandals, due to neglect or violence, is attributed more to this one fact than to any precautionary or supervisory method that has been organized.

HOSPITAL EMPLOYEES' WELFARE

PERSONAL attention to the hospital employee! Why is it necessary? Where should it begin? Where should it end? What must it avoid?

Every hospital has these questions before it.

Why is personal attention any more necessary among hospital employees than among the factory employees across the street? It is not any more necessary. The factory if it be modern and up to date, gives its employees personal attention, far beyond the dreams of ten years ago. It may be a different kind or quality of attention than a hospital should give, but it gives the service just the same. The times demand it in every industrial or commercial enterprise. The hospital cannot avoid it.

The factory's girls probably live at home. Its labor is recruited from the neighborhood. Very often the same family will be represented by two or more members in the same factory.

The factory is selfish in its attention. It expects to stimulate morale; to create pride in its product; to get more efficiency.

The hospital has the same reasons and the same objects in view when it gives attention to its employees' welfare, but there are additional ones. Its help is recruited very often from the rural districts or from sections of the city far distant. Most of these employees are young women, entering a serious and noble profession. Much of their duty is continuous over long hours. Off duty they must remain within call. Whatever of social relaxation they are to have must be had at or near the hospital. The facilities it is the hospital's duty to furnish. It must also throw good influences about its young women, it must feel a responsibility for their good conduct. The dignity of the profession implies high ideals, and the living environments must stimulate such ideals.

Personal attention to the employees' welfare must begin on the day the young woman enters the service. She must feel at once a warmth and sincerity of welcome that opens her soul and attaches her to her new duty. It must disarm her of suspicion and timidity, and inspire her with hope and confidence, but it must end before it becomes patronizing. No employee should feel that she is patronized. Attention must not be paternal or spying or narrow, or supercilious. It must not be given for the soul's sake. The employee will resent the intimacy.

All these mistakes can be avoided by directing attention to the group rather than to the individual. Attention should not be individualistic. That creates friction, jealousies, distrust and favoritism. Everything that is done for the welfare of the hospital employee must be done for the whole number. All must share it equally and freely.

The hospital's welfare service must not have its selfish motive on display. It should be purely social and disinterested. The defect in many welfare organizations in industry is the constant sermonizing upon efficiency and morale. It is so apparent that the employer is doing what he is doing for a selfish purpose that he loses the effect he is after. A hospital may be absolutely free from all motives except a decent desire to afford its employees at all times a wholesome environment. If that be the purpose and the whole purpose, and welfare work is carried on on that basis, the morale, the efficiency, the protection of morals, and all the other desirable results will flow along as placidly as a quiet stream seeking its outlet.

The illusion that times that were are better than times that are has probably pervaded all ages.—Horace Greeley.

HOSPITAL MORALE*

THERE is much more to running a hospital than in merely ensuring good professional treatment and physical care. Mental attitude is important, for the value of morale of patients in promoting recovery is well recognized. Cheerfulness and optimism are therapeutic agents of great value. Every physician knows this—just as he knows that his bedside manner and special attitude toward the case are measures for raising or lowering morale. Sympathy enters, as when the mother kisses the hurt of the child to make it well. Sometimes inert medicaments are prescribed solely for their morale value, while many a tossing patient has been given mental relief and physical rest by the hypodermatic injection of water under the belief that it was morphine. Christian Science capitalizes this by treating imaginary ills with an imaginary remedy. Deft, sympathetic nurses are a great source of help. Probably visits from the families and friends of patients affect their morale more than any other agent. It must not be forgotten that many persons have a morbid, even though illogical, dread of hospital life.

Problems of Morale Largely Human

In every military hospital, the physical surroundings of the sick are well equipped and comfortable. Its problems in morale are thus largely dependent on the manner in which its administrative methods are carried out. This has relation to the human factors of the medical officers, nurses, enlisted detachment, other patients, and outside family or friends. All of these correlate in their effect upon morale. Morale problems in hospital largely fall under the following heads: (1) First impressions on entrance. (2) Attention and care during illness. (3) Interests during convalescence. (4) Mental attitude on discharge.

Every consideration of the morale of patients in hospital must take into account the natural tendency of the patient to become critical and despondent with little to occupy his mind but his own troubles. Those in charge of hospital administration are naturally inclined to resent complaints and criticisms which are often so freely given and usually have little if any foundation in fact. But they should remember that it is a natural tendency to the ailing to disparage surroundings rather than to appreciate that the fault may lie in an abnormal self. Often the sick man, whose system repels food, is unaware of this fact and blames his lack of appetite to an alleged unattractiveness of the diet as to selection, preparation, or serving. Many patients are psycho-neurotics, prone to imagine fault or exaggerate defect. It is clear that such a situation calls for patience and forebearance. If the facts are not as alleged, little may be gained by a disciplinary action which may be the starting point for group sympathy and reaction. But careful study of the individual as being psychologically abnormal will often indicate measures which will alter his outlook, perspective, and attitude.

Interest in Outside Things Important

The chief purpose of hospital morale should be to keep the patient's mind off self and to direct his thoughts through cheerful channels. Interests outside himself and his personal problems should be created and maintained. These interests should be carefully selected to meet the needs of the individual patient. Many of them are naturally of a recreational nature, in which the individual is the passive observer or beneficiary of the efforts of others. But as far as possible, the patient himself should have something which he himself can do, thereby creating interest through the constructive instinct. In some large hospitals, a letter of greeting is sent by the commanding officer to each patient on admission. This displays interest, giving good advice and information, and tends to allay misgiving, create cheerfulness, and promote cooperation.

It is important that the sick be kept in proper touch with their families and friends outside. If they cannot write themselves, letters should be written for them. In serious cases, bulletins of conditions should be sent to the relatives by the hospital authorities. When convalescent, photographs have been taken and sent home to show the state of recovery. Home folks are often kept in touch by sending bulletins on picture postals of the hospital, and by putting parents temporarily on the mailing list of the hospital publication, if there be one. Families deserve to know about the hospital facilities in which their relatives are treated. The medical department has nothing to hide here; the more publicity its well equipped establishments receive, the more it is to its advantage.

Visits from Outsiders Lighten Ennui

Visitations by suitable representatives of women's organizations outside the post are desirable within proper limits. Such organizations and individuals can do much to lighten the lot of the sick and aid the recovery of convalescents. By the news of the outside which they bring, and by the rides and entertainments which they offer, they materially reduce the problems of ennui and discontent. Little personal services are appreciated. Thus free mending and darning for patients have a morale value in addition to any material benefits involved. But such visitors should maintain an attitude of helpfulness toward the hospital and its management and not one of unfair criticism.

It is of much value to have hospital wards adopted by various organizations of local communities. The latter furnish music, entertainers, flowers, and reading material, and have a special interest in the welfare of their wards. They are also of use in allaying local criticism if charges reflecting on the management of the ward are unfounded. When convalescents are members of fraternal organizations the hospital authorities should, if desired, make the fact known to the local lodge. If there are church affiliations, the chaplain will see that the desired relations are promptly established.

In military hospitals, visitation of the patients by officers' wives and others should be encouraged. The patients should feel that their own associates in the garrison are even more interested in them than outsiders. In the past, the captain's wife might visit ailing members of her husband's company, but such action was purely individual. Something organized along general lines is desirable. If the women of the garrison would form themselves into an organization charged with the periodic visitation in hospital of all those needing cheering up, bring a few flowers, reading matter and simple gifts, it would do much to promote cheerfulness, optimism, and contentment. Military hospitals are places in which a high order of medical and surgical skill are provided, but it is perhaps true that the nature of the military service is such that this

*Reprinted from "The Management of Men," by permission of Henry Holt and Company, New York City, and the author, Edward L. Munson, Colonel, General Staff (Medical Corps); Chief, Morale Branch, War Plans Division; (Lately Brigadier General, General Staff).

tends to be rendered in a relatively impersonal way and that the element of human sympathy, which is so valuable and so much appreciated, is proportionately lacking.

Interest of Commanding Officer Long Remembered

Some company commanders make it a practice to visit their men while sick in hospital. Most, unfortunately, do not, and completely fall out of touch with those who are sick enough to need hospital care. Sick men long remember and cherish the interest of their company commander in them in their hour of need, as will all of the men in the organization, for the latter will certainly hear of it and take it as a proof of what the captain would do for them under similar circumstances.

The general problem of hospital entertainment should be approached systematically and comprehensively. As far as possible, what the men want should be furnished. In pursuance of such a plan, the entire personnel of patients and attendants at one hospital was card-indexed as to needs of the individual and his abilities to contribute to entertainment or instruction. In other words, the positive qualities of the garrison were sought out with the specific purpose of using them to remedy or neutralize the negative qualities thus disclosed. The Red Cross assumes the responsibility for remedying outside needs which concern the home.

Music has an almost therapeutic value with some patients. The use of the phonograph, under proper restrictions, is a convenient agency to this end. Phonograph record exchanges will give great variety by rotating the use of records through different wards. Glee clubs, quartets, nurse choruses, and organizations for instrumental music can visit the wards. Band concerts should be a frequent event. Impersonations, monologues, and vaudeville acts can often be carried out. One act plays have been successfully produced in wards with portable burlap scenery painted by vocational classes.

Entertainments Worked up by the Patients Best

More ambitious entertainment can be staged in the hospital clubroom, amusement center, or out of doors. If the plays and programs can be worked up by the patients, with the hospital personnel in the parts, it will create greater interest through self-activity and local application. Wheel-chair contests, with prizes donated by local institutions, have awakened much interest. Playing for the hospital championship in checkers, cards, chess, and other games arouses interest and rivalry. The hospital should, if possible, have its baseball and other athletic teams, not only for the physical value to participants, but for the interest of convalescent spectators. The entertainment of bed-ridden patients is a special problem by itself, due to the physical limitations imposed. A series of bedside games has been worked out at some hospitals. Any recreational equipment, games, supplies, musical instruments, writing materials, smokes, etc., for the patients can be obtained from the Red Cross.

A well selected library should be in every hospital, with its books properly shelved, classified, and catalogued. Further, since many patients cannot themselves come for books, the books should be taken to them by means of book carts wheeled daily through the wards. The librarian should also visit each patient at least twice a week to ascertain what special books are wanted and perhaps suggest some in which individuals might be interested. Now that regiments are allocated to geographical districts for recruiting, it is possible and desirable to secure representative papers from the districts concerned for circulation among the patients.

Local hospital papers are a great aid to morale. Where they do not exist, a special place in the camp or local civilian paper for hospital news is desirable. The news not only arouses interest and satisfies curiosity but opens an opportunity for the men to be encouraged in literary work and the writing up of personal doings and experiences. Ward papers have at times been carried on in mimeographed form.

Should be Taught Some Light Occupation

Patients who are physically able to exercise should be required to do so, under proper limitations, for its mental as well as physical value. If possible, it should be taken in some form as will make it pleasurable and not appear as duty. Croquet, golf putting and quoits are examples of mild exercise. Automobile rides, trips and visits to civilian families and points of interest should be encouraged for men physically able to participate in them. The judicious use of passes for this purpose is a great promoter of hospital morale. When men are in hospital for considerable periods of convalescence, they should be taught some light occupation, such as basket making, wood carving, etc., for the purpose of bringing the constructive instinct into play and diminishing monotony. As soon as patients are able to perform them, they should be given light tasks about the hospital, of a character not to be regarded as drudgery. Tactful presentation will usually result in the man putting himself in the position of volunteering for the opportunity. The care of the hospital flowers, vines, and shrubs, for example, is a duty congenial to most men.

Morale of Attendants on the Sick

Psychological uplift, encouragement and human sympathy cannot be evoked by official order—they must express a state of mind which springs from environment and are a part of general esprit.

The patient in hospital will receive that degree of interested attention and type of care which represents the morale of those caring for him. Physically, this is expressed in a thousand little things and methods, the sum total of which materially affects comfort and peace of mind.

Patients are in a highly suggestible state of mind and react promptly and often in extreme degree to the mental atmosphere around them. In their own distress and doubt, they need to draw heavily upon the strength and confidence of those about them. If attendants are discouraged, depressed and dissatisfied, the sick in their care rapidly fall into the same mental state. Bed-ridden patients are confined to an environment from which there is no escape, hence the special importance of eliminating depressing factors from its components.

It is essential to hospital morale that the patient believe himself in good hands and that he be contented and confident under the conditions to which he must resign himself. He must feel that those upon whom his very existence may depend are not only professionally competent but are personally interested in his case and recovery. He looks especially to the nurses to supply that quality of feminine sympathy which is so craved and appreciated. Some of the more popular nurses can often be made to act as ex-officio assistants of the morale officer. This helps to stimulate their own interest, while information secured by them and measures taken with their assistance can be of great value.

It is apparent that the morale of army nurses and attendants on the sick doubly needs attention, not only as personal and group problems, but for the close relation which it necessarily bears to the morale and welfare of patients. This is a matter too often overlooked, as it is

natural for interest and sympathy to particularly center on the sick, with little reference to the indirect influences which react on the patients from those who have them in charge.

Exercise and Entertainment for Attendants Desirable

For male attendants in hospitals, it must be borne in mind that the relatively housed existence required of them by their special technical duties is unnatural for sturdy young men and may become repugnant to many unless due outlet is afforded for the instincts thus checked. Outdoor sports, exercises and amusements should therefore be particularly promoted in their case, so that their thoughts when off duty may be turned into entirely new channels. Their recreation rooms should be entirely apart from facilities for the sick. As a result they bring back to their patients news of outside activities in which the latter are interested.

The members of the Army Nurse Corps, like anyone else, need systematized exercise to maintain good physical condition. This is not afforded by routine duties and cannot be depended upon as a matter of individual choice. Suitable daily setting-up exercise and periodic walks, rides, tennis, or other appropriate exercise should be required.

With the female sex, entertainments and the social amenities of life count for much. Nurses with personal and socially attractive graces usually meet with no lack in such matters, but there may be others of sterling worth whose similar recreative needs should be given special consideration. Besides entertainments and recreation within the post, acquaintance in the near-by communities is useful. During the war, week-end invitations to private homes were found very valuable in relieving the mental strain of nurses after arduous duty.

IS THE ADMINISTRATION OF ANESTHETICS A ROUTINE PROCEDURE?

THE June eighteenth issue of the *Journal of the American Medical Association*, in commenting on the report of the Ohio Committee on Anesthesia, a committee appointed by the council of the Ohio State Medical Association to investigate matters connected with anesthesia, states that the committee regards the administration of anesthetic agents as being almost entirely a routine procedure, and something which can be done by any intelligent physician or nurse, even by a layman who has had a reasonable amount of instruction in their administration.

Believing that the readers of THE MODERN HOSPITAL would be interested in the opinions of various hospital executives, anesthetists, and surgeons regarding the conclusion of this committee,[1] a number of such experts were asked to write briefly on the subject. Some of their statements follow.

From Dr. Donald Guthrie, the Robert Packer Hospital, Sayre, Pa.:

"I cannot quite agree with the report of the Ohio Committee on Anesthesia—namely, that any intelligent physician, nurse, or layman who had a reasonable amount of instruction is capable of giving anesthetics. I regard the position of the anesthetist as an extremely important one, and believe that in order to administer anesthetics skillfully one must not only be intelligent, but should have long training in the art. This applies not only to the administration of nitrous oxid and oxygen but to ether as well. We have used trained nurse anesthetists in our clinic exclusively for almost twelve years, and their work has been most satisfactory."

From Dr. Thomas Howell, superintendent of the New York Hospital, New York City:

"We wish to go on record as disapproving of the conclusions of the Ohio Committee on Anesthesia.

Not a Routine Procedure

"The administration of anesthetics is not a routine procedure. Many cases must be studied with considerable care to determine the proper anesthetic and its administration. This is best determined by consultation between surgeon and anesthetist. It is true that any intelligent physician can become an anesthetist, usually a satisfactory anesthetist. Some, however, have a peculiar aptitude. In all cases long practice and experience are necessary before satisfactory results can be relied upon. Some general medical practice is desirable.

"We believe that anesthesia should be administered, if possible, by physicians; if this is not feasible, a trained nurse can often be developed to become a good anesthetist."

From Dr. J. J. Buchanan, Mercy Hospital, Pittsburgh, Pa.:

"In every essential point I fully agree with the Ohio committee in its findings.

"I use ether exclusively as a general anesthetic. I believe the use of nitrous oxid and oxygen introduces complicating factors that are without material advantage, if any, and, therefore, to be avoided. I long ago discarded chloroform after nearly losing a patient by its use.

"I think ether is best given by a person who has been well instructed in its use and is regularly engaged in its administration. This can only be a nurse or trained woman who is part of the entourage of the surgeon. Women become more skillful as anesthetists than men.

"The professional anesthetist is destined to disappear, as every good man will find other more important things to do. The responsibility is with the surgeon and cannot be transferred to another."

From Dr. Arthur B. Ancher, City Hospital, St. Paul, Minn.: "Am fully in accord with the opinion of the Ohio committee."

From Dr. W. G. Nealley, superintendent of the Brooklyn Hospital, Borough of Brooklyn, New York City:

Should Be Specially Trained

"I agree, in general, with the conclusions of the Ohio Committee on Anesthesia as published in the June 18, 1921, *Journal of the American Medical Association*, but feel that hospitals should insist on the members of the department of anesthesia being specially trained for such important work.

"The department of anesthesia of the Brooklyn Hospital has the following personnel: (1) A physician, a member of the professional staff who has made a study of, and is proficient in, the administration of anesthetics; he serves without salary but is allowed to charge a private room or private ward patient a fee if he is selected

[1]The Ohio State Medical Association through its House of Delegates, has gone on record as opposed to the nurse anesthetist and has repudiated the Survey of the Special Committee on Anesthesia appointed by its Council.

to administer the anesthetic by the surgeon in charge of the patient. (2) Three graduate nurses, who in addition to having graduated from a hospital have had special training in the administration of anesthetics in a hospital giving a recognized course in anesthesia; they are paid a salary by the hospital. Graduate nurses have been employed here as anesthetists for five years. (3) One intern, each member of the house staff is on anesthetic duty for two months during his two years internship. He is instructed in the administration of anesthetics by the physician in charge of the department, and by the nurse anesthetists.

"Of the total number of inhalation anesthesia during 1920, 2,918 were in operating rooms, 736 in birth rooms, and fifty-one in cystoscopic and examining rooms, making a total of 3,705. Of this number, 120 were administered by the physician in charge of the department, 3,015 by the nurse anesthetists, and 570 by interns."

From Mr. E. S. Gilmore, superintendent of the Wesley Memorial Hospital, Chicago, Ill.:

Men Physicians Not Available

"As a rule, men physicians do not wish to devote their time to the giving of anesthetics, preferring to follow the practice of medicine or surgery. This is perhaps fortunate, as I believe women are better adapted naturally to the giving of anesthetics than are men.

"This means that the official anesthetists generally will be women. The number of women physicians who will give their energies to the administration of anesthetics is also limited. As a result, anesthetists must be recruited almost entirely from nurses or laymen. Personally, I would prefer a woman physician, a nurse, or a layman, in the order given. That a woman with brains can learn to give anesthetics has been demonstrated many times in our Roman Catholic hospitals, where sisters have become exceptionally proficient."

From Dr. J. B. Howland, superintendent of the Peter Bent Brigham Hospital, Boston, Mass.:

"At the Peter Bent Brigham Hospital we use trained nurses as anesthetists with entire satisfaction. In every operation it is the duty of the surgeon in charge to select the anesthetic appropriate to the case, and he feels it his duty to watch the progress of the anesthesia throughout the operation.

"Some nurses and some physicians make good anesthetists while others, no matter how intelligent, do not, certainly not after what you might call a reasonable amount of instruction. It seems to me that, having selected the nurse as perhaps the most available to train as an anesthetist, it is a matter of the greatest importance that she be encouraged, if interested and suited to the work, to continue, because only by experience can she become proficient, and every year she continues as an anesthetist makes her more valuable and dependable.

"It seems to me that the minimum time to be spent even in a busy clinic in learning to give nitrous oxid anesthesia should be six months, and even then there would be much to learn before the nurse would be able to give an anesthetic as well as the surgeon has a right to expect."

THE LEO N. LEVI MEMORIAL HOSPITAL

By REGINA H. KAPLAN, Superintendent, The Leo N. Levi Memorial Hospital, Hot Springs, Arkansas

THE Leo N. Levi Memorial Hospital is very unique in its existence as well as method of treatment. It is a purely charitable institution admitting no one who is financially able to pay and maintained completely and entirely by voluntary subscriptions and annual appropriations from the various lodges of the Independent Order of B'nai B'rith, from charity institutions and individuals.

The hospital was named after Mr. Leo N. Levi of New York, a very prominent member of the B'nai B'rith, which is a Jewish fraternal organization extending to the four quarters of the globe. The hospital is a modern institution, equipped with up-to-date medical facilities. Among other things it is provided with the radio-active Hot Springs water baths. The capacity of the hospital is seventy-five beds, divided into four large wards, and two emergency rooms.

Arrangement of Hospital

The first floor is devoted entirely to the out-patient and the social service department, in addition to the main office. The second floor contains the patients' dining room, nurses' dining room, kitchen, laboratory, bath house, operating rooms, and superintendent's apartment. The third floor contains the wards, dressing room, linen room, patients' library, diet kitchen, two sun parlors, and entrance from the ward into the park. The fourth floor is the nurses' quarters exclusively, including their sun parlor and sleeping porch.

The facilities are open to every lodge and charity organization, and the institution is non-sectarian.

The requirements for admittance are that the applicant must come recommended through his local B'nai B'rith Lodge or a responsible charity organization, Jewish or non-Jewish. The patient must have return transportation guaranteed by the organization through which application is made so that the burden of transportation is not imposed upon the local community. Application blanks are sent upon request to any locality. They are then returned duly signed, and placed before the board of admssion for consideration. If accepted, the patient is immediately advised to proceed. The usual length of stay is from two to four months.

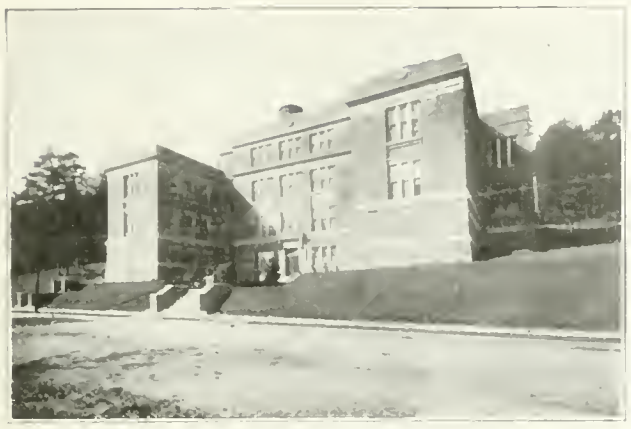
Nature of Diseases Treated

The following statement has been officially accepted by the medical board and board of managers of the Leo N. Levi Memorial Hospital as an authentic report of conditions most benefited by Hot Springs treatment.

"Experience and careful observation have shown that the beneficial effects of the natural thermal waters of Hot Springs, Ark., are due, in all probability, to their action on metabolism and elimination, and that the medical conditions most benefited are those in which the disturbance is due to a toxemia, either of bacterial or metabolic origin.

"Under the first heading may be classed the infectious rheumatic diseases (both gonorrheal and acute articular), syphilis, and malaria. The second group includes gout and chronic arthritis, neuralgia, all forms of nephritis, chronic skin diseases, especially the squamous varieties, and chronic cardio-vasculo-renal disease with increased arterial tension.

"Benefits may also be expected in anemia and other diseases of the blood and blood forming organs, diseases of the ductless glands and catarrhal conditions of the



The Leo N. Levi Hospital, Hot Springs, Ark.

gall bladder, bile passages, and gastro-intestinal tract.

"The baths are distinctly of no value in all forms of tuberculosis and malignant neoplasms."

Admission to the hospital, of all the above mentioned cases, regardless of their severity, is not, however, contemplated. Its facilities will not be extended to mild and transient cases which should yield to ordinary ambulatory treatment, but are reserved for those cases of a serious and obstinate character, which, though resisting ordinary methods of relief, promise a rapid and permanent recovery from the use of the waters of the Springs.

Baths

The bath house consists of two wings, one for men and one for women. Each contains three bath rooms, two bath halls, one vapor, three cooling rooms, and lavatory. The baths in each instance are prescribed by the physician on service, and given by a registered attendant. The temperature of the bath hall during bathing hours is 102°F.—the water generally from 96°-100°. Cooling rooms graduate from 90° in the first room to 70° in the last; until all baths are given, the temperature in the wards remains about 70°F.

The laboratory is equipped fully, and there any and all tests are made by a thorough and competent technician under direct supervision of the medical staff.

The x-ray department is not complete at the present time, but it will be shortly.

The medical visiting staff consists of seven prominent local physicians and surgeons who serve for three months each year, whereby the patients receive the most skillful attention as well as close observation.

The hydro-therapy room at the Leo N. Levi Hospital.

The Dispensary

The hospital also maintains a free dispensary, which has become a United States Public Health clinic and has a daily average of one hundred and fifty patients. It has been in existence only eighteen months, but during last year 3,679 patients were treated. This dispensary is the only one in the city and all medications as well as treatments are given free. Physicians and surgeons give their time cheerfully for this much needed cause. Any person receiving dispensary care who becomes unable to assist himself is admitted into the hospital proper.

The dispensary consists of the various departments: syphilis, and skin, neural syphilis and nervous diseases, eye, ear, nose and throat, genito-urinary, surgical, children's, x-ray.

About 75 per cent of the daily average are venereal diseases.

The interdepartmental social hygiene board is supplying all the necessary salvarsan used in the dispensary, which last year cost over $3,000.

The hospital is growing each year and there is every reason to expect that the Leo N. Levi Memorial Hospital will sometime be among the greatest national philanthropic institutions.

SERBIAN HOSPITALS

By HOMER FOLKS, Former Commissioner of Charities, New York. Special A. R. C. Commissioner to Europe.

To an American accustomed to the hospital as a place adequately equipped for the care and cure of the sick, no greater disappointment occurs than on his visit to a Serbian hospital. The Serb doctor is not an adept at hospital management. He knows how to diagnose and to treat individual patients, but he has no technique of hospital administration.

No Dickens has yet set forth the frailties of the Sairey Gamps of the Serbian hospitals. Perhaps a Dickens could do it, it would be a task worthy of him. Trained nursing does not exist. There are men orderlies and women helpers, but neither orderliness nor much help results. Trained nursing the world over is only half a century old, and things move faster now than they did fifty years ago. What required the pen of a Dickens and the genius of a Florence Nightingale may be done more easily in Serbia.

It is quite customary to place all sorts and types of patients in the same ward, except those which are technically deemed contagious, such as smallpox and one or two others, but not including the great majority of what we ordinarily call communicable diseases. There are many patients in serious stages of venereal diseases but with no isolation, no separate dishes, no measures to prevent infection.

Add to this, the fact that the Bulgars, Austrians, and Germans stripped the Serbian hospitals of every form of equipment, and that it has been possible as yet to meet but a small part of these needs. Some of the hospitals have one sheet per bed, and some have none. The patients nearly always sleep in the clothes which they wore when they came to the hospital.

The average Serbian peasant has an inveterate opposition to going into a hospital. This perhaps must be put down as doing credit to his good judgment.

The Serbians are not wholly oblivious to these shortcomings, and have recently asked the Serbian Child Welfare Association, which with American Red Cross aid is

operating child health centers with American trained nurses in many parts of Serbia, to place one or more of these trained nurses in the Serbian hospitals in order to introduce American standards of hospital management. It would take a stout heart to face these difficulties, but then the American Red Cross nurses are of the stout-hearted kind. The following is a note by Allan Murray Gale, Serbian Child Welfare Association of America:

In his report of June 22, to the Serbian Advisory Council of the Serbian Child Welfare Association of America, of which Bishop Nicholai Velimirovic, who lately visited America, is chairman, and among whose members seven of the Jugoslav Government ministries and all of the Serbian civic organizations for child welfare and reconstruction are represented, Dr. Reeder, the Association's Commissioner for Serbia, speaking of the trained nurse in Serbia, said:

"Since the last meeting of our Council active measures have been taken toward the establishment of a nurses' training school in Belgrade. Our Commission initiated the movement by calling a meeting of the various organizations in Belgrade who would naturally be interested in such a work. Several meetings have been held; the co-operation of the League of Red Cross Societies has been enlisted in the enterprise, and subscription of funds to the extent of about a million and a half dinars has thus far been received. The League of Red Cross Societies has agreed to furnish the directrice for the school, and Miss Enid M. Newton has been appointed to that position.

"The ground for the site of the personnel house for the nurses has been selected and plans for the building have been made.

"The new directrice of the school will arrive in Belgrade on July 4.

"Thus we have every encouragement to believe that the first fully established nurses' training school for Serbia will soon be installed. There is probably no other single forward step that can mean as much for the public health of Serbia in the future as the establishment of this school. The hospitals of Serbia, Montenegro and Macedonia, of which there are over fifty, are in greater need of trained nursing service than any other one thing. These hospitals are not patronized by the better class of people and very few, if any, of the doctors would be willing to entrust the members of their own families for care in most of these hospitals. This is due chiefly to the lack of sanitary standards maintained in the hospitals. Trained nursing will raise these standards to such a degree as to command the respect and patronage of all good people. This has been the history of trained nursing in other countries. Our Commission therefore feels that aid toward the establishment of trained nursing is one of the most important contributions it can make to the welfare of Serbia."

The American Commission to Serbia of the Serbian Child Welfare Association of America derives its funds from voluntary contributions of the American public and donations made to it by organizations through its headquarters at No. 287 Fourth Avenue, and as Dr. Reeder has elsewhere said, the amount of the vitally urgent work which it can do in Serbia is practically limited only by the amount of money it receives to put into it.

AMERICAN ASSOCIATION OF HOSPITAL SOCIAL WORKERS HAS LIVE MEETING

The annual meeting of the American Association of Hospital Social Workers at the time of the National Conference of Social Work in Milwaukee in June, brought together workers from all over the country who had common problems to discuss, and were eager to participate in an exchange of experiences. At the first meeting representatives of the social service departments in different sections of the country discussed the report of the committee appointed by the American Hospital Association to make a survey of hospital social service departments. The outcome of this meeting was the appointment of a special committee to formulate a statement of the function of the hospital's social service department. The statement submitted by this committee, and adopted by those present, is very similar to statements made in the report of the American Hospital Association committee.

At the group meetings problems of organization, questions of record keeping, topics of special interest to psychiatric workers, and the imperative need of courses in training of hospital social workers, were subjects for lively debate. A section for psychiatric social workers was provided, on request from a number of psychiatric workers who wish to get together under the auspices of the American Association of Hospital Social Workers. Membership in the section is dependent on membership in the American Association, and on meeting special training and experience requirements of the section. A committee on training was appointed to work with the committee on "training for hospital social work" of the American Hospital Association, to yield the experience and point of view of the "worker-on-the-job."

Through all the meetings there was an awareness of the relatedness of hospital social work to other forms of social and health work. This was concretely expressed in the program adopted for the ensuing year, which approves the preparation of an exhibit for use at meetings of national and local groups, such as the National Conference of Social Work, the American Hospital Association, the American Medical Association, and, in addition, urges members to participate in meetings of related groups.

Will Publish Bibliography

It was voted to publish a bibliography on hospital social service, and this will be ready at the Association's semi-annual meeting at the time of the American Hospital Association's convention in September.

Since the Montreal meeting last fall, districts of the Association have been formed in the New England States, New York, New Jersey, Pennsylvania, Missouri, Maryland, Delaware, Illinois, Minnesota. The getting together locally of groups of hospital social workers has been vital in helping to make the Association articulate. The districts can be a tremendous stimulus to each other, through the medium of the American Association. Everyone realized the necessity of having an executive secretary in order to help the districts develop their own resources, and it is expected that such a secretary will be appointed in September. In the interim, Ruth Emerson, who has been the executive secretary during the past year, will continue.

At the business meeting, officers were elected as follows: President, Ida M. Cannon, Boston; first vice-president, Suzie Lyons, Boston; second vice-president, Gertrude L. Farmer; treasurer, N. Florence Cummings, New York; secretary, Ruth V. Emerson, Washington, D. C.

The new members elected to the executive committee for two years are Margaret Brogden, Baltimore; Harriet Gage, Chicago; Mary C. Jarrett, Northampton; Edith Howland, Washington; and Kate McMahon, Boston. The following are also on the executive committee: Mrs. Bert Russell, Chicago; Mary Wadley, New York; Antoinette Cannon, New York; Deborah Barns, Fall River; and Mary Combs, Brooklyn.

The advisory council is composed of Dr. Richard Cabot, Boston; Mr. Michael M. Davis, Jr., New York; Dr. C. P. Emerson, Indianapolis; Mrs. Helen Glenn Tyson, Pittsburgh; Dr. A. R. Warner, Chicago; Dr. McFie Campbell, Boston; Miss Mary Richmond, New York; Dr. Frank Billings, Chicago; Miss Adelaide Nutting, New York; Miss Edna Foley, Chicago; Dr. Alexander Lambert, New York; Dr. W. P. St. Lawrence, New York; Dr. Winford Smith, Baltimore; Mr. John Ransom, Chicago.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
132 E. 45th Street, New York City

COMMENCEMENT WEEK AT ARMY SCHOOL OF NURSING

BY ELIZABETH MELBY, FIRST LIEUTENANT, CHIEF NURSE, A. N. C., WALTER REED GENERAL HOSPITAL, WASHINGTON, D. C.

THE second week of June marked the graduation of the Army School of Nursing at the Walter Reed General Hospital, Washington, D. C. The class to graduate was the famous war class of 1918. Of the eighteen hundred young women who qualified for training that year in the Army School, five hundred and ten remained for completion of the course, four hundred and four graduating on June sixteenth from Walter Reed General Hospital, Washington, D. C., and one hundred and six on July fourteenth from Letterman General Hospital, San Francisco, Cal.

The first event was the commencement dance, the evening of June tenth, at the Red Cross House. It was a time of happy greetings, as practically every one of the four hundred students had returned to their alma mater. The attractive recreation room was very gay with flowers and Japanese lanterns, and an excellent orchestra supplied the music. Caps, whistles, fans and paper confetti added to the fun. Punch, sandwiches and cakes were served during the evening. It was indeed a delightful introduction to the graduation time.

The following day, Saturday, was the day of the Army Nurse Corps picnic to the Army School of Nursing. It was then that the lovely picnic grounds of Rock Creek Park found voice and to one of the students related this happy incident.

"I used to be like any other part of Rock Creek Park—just ordinary, a place where folks gather to enjoy me and where grass and trees grow to beauty. But a great change came upon me last Saturday when the graduate nurses of Walter Reed Hospital gave a picnic to the students. Early in the afternoon the graduates came in big army trucks loaded with every kind of an article that might be needed for decoration, amusement, and consumption. They decorated me with many gaily colored balloons and Japanese lanterns, and flags which were hung from tree to tree. A tent was pitched in which sat two of those mysterious ladies who hold your hand and thrill you with news direct from your heart and head; long tables were set; and bats, balls, rings, and boxing equipment piled on the ground. Nor was the childish fancy of the guests overlooked, for behind a protecting bush was Tony with his hurdy-gurdy that played welcome to the first, and farewell to the last. Yes, and with all of this, they had food—so much food! All plates of the open air stove were busy—real cooks and chefs with caps and aprons, cooked and stirred things. Even the most ambitious guests were not allowed to help, for the hostesses insisted upon serving alone, the starving five hundred. Great baskets of hot-dogs, roasting ears, tomatoes, sandwiches, and cheese were passed, while side tables accommodated drinks, cakes, candies, nuts, and watermelon. I never have seen or heard such a picnic. Nothing was forgotten—not from soup to nuts, but from hot-dogs to

Schutz Photograph Company, Washington, D. C.

The class of 1921, Army School of Nursing

fireworks. Yes, it did rain, too, but I don't believe anybody noticed it. At least the rain couldn't drive them home. It was just the 'last bus' and the fear of having to walk."

At twilight on Sunday evening a large audience gathered in the cool green amphitheater of the formal gardens for the baccalaureate sermon. As the strains of "Onward, Christian Soldiers" floated from the music pavilion, the student nurses in their pretty summer gowns marched in procession down the winding walks to the places reserved for them. Then followed the inspiring address by Colonel John T. Axton, Chief of Chaplains, United States Army. His message to the class was steadfastness, courage, and service. In conclusion, leaning earnestly forward, he said, "I want to risk being commonplace and outline a few of the things which make you what Edith Cavell was and is. A public man in America was asked what is considered the cause of poverty and distress in our country. He said, "This condition is due to two things on the part of women and men; lack of decision, and lack of that application and perseverance which pegs away and makes a thing possible. It is frivolity, indolence, lack of decision and application, and of that perseverance which pegs away and reaches the top.'"

Then followed the beautiful sacred concert given by the members of the Sixty-fourth Infantry Band of Camp Meade, Maryland.

The students gave their farewell party to the patients, to their "Heroes All" whom they were leaving after three years of service, on Monday evening. First was the moving picture, "Heroes All," featuring the life, activities, and treatment of the overseas patients at Walter Reed, then the Army School of Nursing songs which all sang with such great vim; operating room scenes, demonstrating such marvelous aseptic technic; and for dancing there was the Alabama cake walk, and Madame de Frenchy's remarkable interpretation of esthetic dancing. Last was the mock wedding, the marriage ceremony of Corporal Ethics Anatomy and Nurse Materia Medica. Delicious refreshments were served and the party was over. This was perhaps one of the most enjoyable gatherings ever held at the Red Cross Hut.

Tuesday was class day. After a brief address by Major Julia C. Stimson, Dean, Army School of Nursing, the class poem was given. Then the history was read, recalling the days in the fall of 1918 when the telegraph summons "Come at once" opened for each student the life of the Army camp. In the review of the athletics of the school year—basket ball, tennis, swimming, horseback riding, baseball and military drill—the importance of athletic training was well summarized, "These forms of athletics have had a three-fold value in the Army School of Nursing. Physically the students speak for themselves, as on the whole they are healthy, energetic, and well developed. Interscholastic games have removed the barrier between a nursing school and other institutions of learning. Aside from this social value, the mental relaxation which follows such activity is of decided importance. Organized athletics have proved such a success in the Army School of Nursing and in some other nursing schools, that in time they will be included in the standard curriculum for schools of nursing."

The future was made plain to the prophet of the class, who gazed into a bowl of cresol solution and saw twenty-eight bubbles, each bubble to her magic sight revealing the impish face of some one of the units of the Army School originally established at the military cantonments, thirty-one units in all, twenty-eight now concentrated at Walter Reed. Eagerly they disclosed to her the callings of her classmates. The president of the class planted the ivy, fittingly obtained from the gardens of Martha Washington's Home at Mount Vernon. The ivy planting was commemorated by the placing of a bronze tablet in one of the cement pillars of the western stairway leading into the garden of roses. A silver trowel engraved with the class numerals had been made in the occupational shops by one of the patients, and given by him to the class. After its initial use it was presented to the Juniors. In accepting it, the president of that class said, "In the name of the class of 1923, for whom I am privileged to speak, I pledge to you, honored Seniors, and to the staff of our grand institution, unswerving fidelity on our part to the ideals and traditions today entrusted to our care." To the Juniors the class bequeathed the dearest possession of the school—"Oh, ye Juniors, we will you our boys—how we hate to leave them." After this final great gift had been made, the St. Mary's Band play as its closing selection "The Star Spangled Banner," and the exercises of class day were at an end.

In honor of the graduating class and the hundreds of

Commencement Exercises of the class of 1921, Army School of Nursing

relatives and friends of the students, the faculty gave a beautiful reception Wednesday afternoon, June 15, at the Nurses' Quarters Number One. Everywhere were baskets and bowls of flowers. The training school office was stripped of its businesslike desks, chairs, and filing cabinets, and in their places were tables laden with delectable dainties of all descriptions. Flowers and flickering candles added their charm to the scene, and to everyone the tea party was made the more enjoyable by the presence of the St. Mary's Band of Baltimore. The guests were received by Major General Merritte W. Ireland, Surgeon General of the United States Army; Colonel James D. Glennan, Commanding Officer, Walter Reed General Hospital, Washington, D. C.; Major Julia C. Stimson, superintendent of the Army Nurse Corps; Captain Harriet H. Barnes, assistant superintendent, Army Nurse Corps; First Lieutenant Anne Williamson, chief nurse, Walter Reed General Hospital; and a committee of the class members.

Very early commencement morning, long even before reveille was sounded, students were awake and hastily assembling at quarters. The reason was most momentous. For this was the time of the appearance of the School Annual. This Annual was compiled by the students in their desire for a memorial of their days in training, and was dedicated, as an appreciation to all Americans who took part in the World War, to the "Spirit of 1918." When assembled for the commencement exercises, but previous to the military review, the students presented as a token of their gratitude, love, and respect, a handsome silver loving cup inscribed with the insignia of the Army School, to their commanding officer, Colonel Glennan.

On June sixteenth, at ten o'clock in the morning, there were present in the reviewing stand Major General Merritte W. Ireland, Surgeon General of the Army; Brigadier General Walter D. McCaw, Brigadier General Robert E. Noble, Colonel James D. Glennan, Miss Annie Goodrich, Major Julia C. Stimson, superintendent of the Army Nurse Corps, and dean of the Army School of Nursing; Captain Harriet H. Barnes, assistant superintendent of the Army Nurse Corps; and the faculty of the Army School of Nursing. Before them the entire personnel of the hospital passed in review, the officers under command of Colonel Glennan, the detachment men headed by Major Maddux, the Red Cross organization, the occupational and physiotherapy aides led by Elsey Taft, the graduate nurses in charge of Anne Williamson, and finally, the class of graduating nurses.

Reaching a point on the lawn, the officers and detachment men divided, making review lines for the oncoming women whose organizations each in turn divided to review the marching students, who passed on to the place reserved for them.

Suppe's overture, "Light Cavalry," played by the United States Marine Band, opened the commencement exercises. Major Stimson then introduced the speaker of the day with a speech a portion of which was as follows:

"It isn't often that anyone has the good fortune to bring together in an official, public way and under such happy auspices as these, the prophet and the fulfillment of the prophecy, but that is my good fortune today.

"Three years ago, in the confusion of needs and the many suggestions that were made to meet these needs, one woman had a vision of this school. Her vision was a plan to meet the insistent call for help in the nursing service of the Army, and at the same time to prepare young women who were eager to respond to their country's call, for a career after the war was over. The plan was stupendous because the very idea of a school for nurses in the Army was an absolutely new one, and was beset with almost insuperable obstacles. The plan, however, went further than these two things—to meet the need and to give a nursing education—and had another object, to give a nursing education that could be surpassed by none offered in this country or any other. It seemed an overwhelming, far-sighted, impossible proposition.

"As founder of the Army School of Nursing, and as administrator of its affairs for the first year and a half of its existence, she is entirely responsible for what has been accomplished in this school. And so it is with profound emotion and satisfaction, as a humble follower in her steps, that I introduce, not Miss Goodrich to the school, but, on the other hand, present the dream to the dreamer."

The message given by Miss Goodrich was one of deepest inspiration and through all time will ring true in the hearts of her followers:

"I want to say that there never was an occasion when

Schutz Photograph Company, Washington, D. C.

Walter Reed General Hospital, Washington, D. C., June 16, 1921.

I so much wanted to speak of what is in my heart, but it is a difficult thing at this great moment to say the word that is effective. No woman ever faced an occasion when she more longed to give a message that would carry. I cannot tell you of all that has happened in my mind within the last few days whenever I tried to think of that which I should say to you as you finish your training today. One thing has been uppermost and that is, 'What will they do with it?' You are going out, five hundred strong, into a field that needs you greatly. As I have pondered on what I would say to you, I looked into the future and I saw those East Side streets with the children growing up to make future citizens; and then, looking across the way to the University, still that thought has haunted me—'What will they do with it?'

. . . . . .

"Never let anyone tell you there is evil in dreams—although a dream which is not followed by action is not a good thing. Do not spend your life in dreams; but a dream that takes effect in constructive action is the finest thing that ever happened. Many years ago a Spaniard dreamed of a great country and three hundred years later a great French general helped carry his dream forward, and not so many years after, a great American general stood between death and the whole world, and invoked the spirit of the great French general with the words, 'La Fayette, we are here!'

"Dear colleagues, let us dream together that you go out and that you go through this land and every other land and make your successors do the same; raise a great army, so that in every country we shall have two million nurses going down to conserve the life of the little child. And when this great army has made the life of the little child safe, then you can invoke the spirit of Florence Nightingale with the simple salutation, 'Mother of Nursing, we are here.'"

Before presenting the diplomas to the class, Surgeon General Ireland gave a brief address, saying:

"I am about to accomplish one of the pleasantest duties that I have ever been called upon to perform, for it is with a peculiar sense of gratification and pride that I shall present the diplomas to this first and historic class of the Army School of Nursing. The pride is for two very definite reasons. First, that this large group of young women now completing their course of training as nurses represents the finest evidence of the patriotism of the women of America, and the determination on their part to make their patriotism effective in terms of actual service and in deeds rather than in words. The second reason for my pride is that the Army, and the medical department of the Army has had the opportunity to guide their efforts in fitting themselves for a life of usefulness, not only to the country in its time of need, but to all the communities of which they will be a part.

. . . . . .

"Thousands of men owe their present state of well-being, if not their lives, to the ministry of nurses. Your part in this tremendous reduction of mortality and permanent disability has been a large one. Too great appreciation cannot be shown you for the spirit with which you volunteered to take your place in our hospitals when the need of your services was so great.

Shortage of Nurses a Challenge

"The Army still needs you, because we have had placed upon us a task which we had not foreseen—that of taking an important part in the rehabilitation of ex-service men. Nurses are needed everywhere throughout the country, as of course you know. The shortage is really a thing to be proud of, because it shows an awakening all over the United States of the need for and the usefulness of nurses and the important part they are to take in the prevention of disease, as well as in its cure. This shortage is a challenge to every one of you, not only to do your own part, but to see that others come to stand by your side in the big field that is opening before you."

The exercises of commencement day were brought to a close by the presentation of the Rea scholarship. The scholarship was given by Mrs. Henry Rea of Pittsburgh, the first field director of the American Red Cross at the Walter Reed Hospital during the war period. It is for fifteen hundred dollars and covers tuition and maintenance for a one year course in hospital administration, or instruction in the Department of Nursing and Health, Teachers College, Columbia University in New York. Brigadier General Walter D. McCaw, head of the Army Medical School, presented the scholarship to Miss Barbara M. Price of Rochester, N. Y., "the first among her equals."

Later, in assembling at the Recreation Hut, the students found scores of telegrams, letters of congratulation, baskets of flowers, and a most lovely farewell gift from the aides, an enormous cake, its white frosting decorated with a huge bluebird bearing the greeting, "From Bluebird to Bluebird."

The following day the graduates of the Army School met for the organization of an alumnae association. The meeting was most enthusiastic. With its watchword "Carry On" the association will hold together the student body and keep alive their love for their alma mater.

In the evening was the dance given the graduating class and their guests by the Knights of Columbus. The Knights of Columbus Hut was gaily decorated with flags and lanterns, and the music was by Hughe's Orchestra, composed entirely of overseas veterans.

The culminating event of commencement week was the pageant written and presented Monday evening, June twentieth, by the class of 1921 of the Army School.

With General John J. Pershing as guest of honor, and Surgeon General Merritte W. Ireland, General Peyton C. March, Major General James W. McAndrews, Brigadier General W. D. McCaw, Brigadier General R. E. Noble, Colonel James D. Glennan, Doctor Livingston Farrand, Miss Mabel Boardman, Miss Clara D. Noyes, Major Julia C. Stimson and staff, the personnel of Walter Reed, the relatives and guests of the students, besides many other persons prominent in official and social life in Washington—an enthusiastic audience of five thousand and over—the pageant, "A Vision of the Future," will long be remembered as a splendid achievement of the class of 1921.

Pageant a Great Success

Written by two members of the graduating class, Dorothea Hughes and Mabel Dalton, and acted by the entire personnel of the Army School, many patients of the hospital and numbers of enlisted men, it was at once the most unique, the most beautiful, and the most appealing event in pageantry witnessed in the national capitol in recent years. The pageant was produced under the personal direction of Marie Moore Forrest of the Community Service, national pageant director, assisted by members of her staff, by Mrs. Albert N. Baggs, by Anne Williamson and Elizabeth Melby, chief nurses of the Army School of Nursing, by Caroline B. McKinley, who arranged and directed the beautiful dances of the winds, and by hosts of friends on the post and in Washington.

The formal gardens at the hospital were made even more lovely than usual; the stage was selected, and arranged by placing a grassy mound in the midst of a clump of wonderful willows. Specially made colored screens for

lighting effects added greatly to the charm of all the dances and scenes, which the rising full moon made even more wonderfully beautiful.

The pageant opened just at dark, with the United States Marine Band playing Handel's Largo; then, in the distance Humanity appeared in a ray of light, with children clinging to her robes, led hither and thither by a surging troubled group of the Winds of the earth—wonderful in their colorful costumes and in their graceful dancing—until from the West came the radiant Star of Hope, who greeted distressed Humanity and led her off in search of help and happiness. This closed the prologue.

At once out of the darkness appeared a vision of the Red Cross Mother, who gladly received troubled Humanity, while the Star of Hope dispersed the tempestuous Winds to the earth's four corners. The music changed to a stirring march and a sound of echoing bugles. A wave of enthusiasm greeted the United States Army troops who came marching to meet the big band of student nurses gathered about the Red Cross Mother and there the United States Army made the gift of its nurses to the Red Cross Service of the world. It was beautiful in its symbolism and impressive in its simplicity. In response to their plea, "Show us the work that lies to our hands," the Red Cross Mother offered them a vision of the world's work for Humanity, that they might choose whom they would serve. Then appeared a group of Winds in a lovely dance of the Orient, arrayed in the gorgeous flaming colors of the East; in their wake a standard bearer heralding a vision of Japan—its fascinating life as well as its needs pictured in the dainty tea room scene. It was a charming vision, with quaint lighted lanterns, beautiful costumes, and dances.

A quick transition from gayety to sadness, and the West Winds came, bringing a messenger, riding fast, and a vision of disaster at the mines. Scenes followed quickly, heralded always by the spirit of the Winds;—an Indian village with its silent pathos and lonely campfire faded away before the cold North Winds, passing through with their vision of Polish life, both grave and gay. Followed a realistic scene from the great American metropolis, a veritable vision of Henry Street in its "busy" hours, showing the street life of the slums with its comedy so close to tears.

Thus it repeated itself, ever the need of Humanity in varied form. Desert people of Arabia came, Spain with its dancers, the gaunt and stalking poor of Russia, Belgium, and France with its brave but broken peasantry passed by, each with its special appeal.

A Scotch scene with kiltie band, "highland fling" and Red Cross collie dog was received with keen delight. The heart of the audience responded warmly to the passing Irish vision of the lonely bowed old mother with the ragged children, the dainty colleen and her romantic young lover. England followed with a vision of Florence Nightingale and a group of English nurses with the call to comradeship. A wave of silent pity went out to the Armenian children in their desperate need, and to the starving Chinese begging for food. Then happy Winds brought on two lovely scenes, one from Greece, in which classic dancers of past ages gave place to folk dances of the present, and one from India with its oriental colors, its glory and squalor.

At last from a distance, the familiar strains of "Over There" were heard, and in came a procession of the Walter Reed patients from the wards, the war's real heroes. Cheers of love and gratitude greeted them, in response to their sure appeal. As they finished singing "To the Girls of the A. S. N." they were given an ovation. The Marine Band softly played the beautiful Kipling-DeKoven recessional, "Lest We Forget," and the Red Cross Mother and Humanity moved out, closely followed by the Army troops, the standard bearers, and all the different nations, and after them the patients and their comrades and student nurses. The inspiring strains of the grand march continued, till the last bit of khaki and the last flutter of blue passed out of sight.

Such was the pageant, written and planned by students, which was straight from the heart of the class, showing their dreams of the future.

AMERICA'S FIRST TRAINED NURSE*

IF I were privileged to add something to the many wise things which will be said to you nurses this evening, I think I would want to speak of the compensations which may come in you as a reward. Of all the compensations I think of, I would place first the opportunity to make friends—real lifelong friends. There comes to my mind a little book, written perhaps ten years ago, which I have recently read, that is full of inspiration, not only for nurses, but for everyone who would have his life or her life count most for others.

I refer to "Reminiscences of America's First Trained Nurse," by Miss Linda Richards.

I will not attempt an abstract of this gem of inspiration. If anyone here has not read the little book, he or she has a treat yet to enjoy.

Dr. John C. Berry, our own Dr. Berry, has written something worth reading about "America's First Trained Nurse," especially of her work as nurse, organizer, and teacher in Japan.

Dr. Edward Cowles, a former superintendent of City Hospital, Boston, McLean Hospital, Waverley, and a one time good friend of mine, has added to our appreciation of our "First Trained Nurse." In chapter one, Miss Richards tells how the sick were cared for in the days before there were training schools. She has something to say of the so-called "born nurse" who received no compensation save that of an approving conscience and the honor of bearing the title "born nurse," the true meaning of which, in her mind, was "the possessing of qualities which, with proper training, go to make the ideal nurse: a love of ministering to those in need, a quickness to observe symptoms which should be reported to the doctor, a gentle touch, a sympathetic nature, and a love of nursing for the very work's sake." These are Miss Richards' own words. Yes, indeed, no one can say it better, "A gentle touch, a sympathetic nature, and a love of nursing for the very work's sake"—these are qualities above price, which, with proper training, go to make the ideal nurse. She it is who easily wins a long list of lifelong friends. These are gifts from God and from your own dear mothers which I wish for every one of you who have worked with us from the early days of your probation to June, 1921.

*Introduction of Miss Linda Richards to the graduating class, City Hospital, Worcester, Mass., June 24, 1921, by Charles A. Drew, M.D., superintendent.

ANNOUNCE EXAMINATION FOR NURSES

The United States Civil Service Commission announces an open competitive examination for trained nurses for filling vacancies in the Federal Board for Vocational Education and in the Indian and Public Health Services.

Applicants should apply at once for Form 1312, to the Civil Service Commission, Washington, D. C.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU GRAVES,
5618 Winthrop Avenue, Chicago, Ill.

A HIGH FAT DIETARY FOR DIABETIC PATIENTS

BY BRETA M. LUTHER, DIETITIAN, ILLINOIS TRAINING SCHOOL FOR NURSES, CONNECTED WITH COOK COUNTY HOSPITAL, CHICAGO, ILL.

THE fact that diabetes is a disease which can be treated through the adjustment of the diet to meet the needs of the individual case has been known for some time. Different specialists have worked out their own systems of meeting these needs. The Allen, the Sansum, and the Van Noorden treatments are examples of such systems commonly used in hospitals at the present time. There has, however, come to our attention a new method advanced by Dr. L. H. Newburgh and Dr. P. Marsh of Ann Arbor, Mich. Instead of the high protein, low fat, and low carbohydrate diet, which is characteristic of the Allen method, the Neuburgh diet consists of a low protein, low carbohydrate, and high fat content. It differs also in the fact that the starvation period is not introduced. The caloric value of this diet soon surpasses that of the entire Sansum group diet as given in the Rush Medical Dispensary Pamphlet of 1920.

In his article[1] on a high fat diet for diabetics, Dr. Newburgh states that a patient on entering the hospital receives a diet of ten grams protein, ninety grams fat, and fourteen grams carbohydrate with a total of about nine hundred calories. When the patient becomes sugar free (one to two weeks), the diet is advanced to twenty-eight grams protein, one hundred forty grams fat, and fifteen to twenty grams carbohydrate, with total calories fourteen hundred. This diet is sufficient for a small person. For a large person an increase may be made in the diet, which brings the caloric value to eighteen hundred, the protein, the fat, and the carbohydrate being thirty to forty grams, one hundred seventy grams, and twenty-five to thirty grams. Further additions may be made. Some of the facts he attempts to prove are: that glycosuria is avoided, that acidosis is not precipitated, that the nitrogen equilibrium is maintained, that the patient leads an active, comfortable life. His work tends to prove that these facts are confirmed.

When this diet was tried in the special diet kitchen at the Cook County Hospital, certain limitations were met, due to the fact that, though the food supply in the hospital is of sufficient amount and of good quality, there is not the variety to choose from which one desires in the making up of a special diet. Choice fruits, vegetables, meats, and garnishes, such as special flavorings, coloring matter, and the like are not available. Only such fresh supplies as are in season can be depended upon for use. With these restrictions the following diet examples were planned and used for the diabetic patients in the hospital.

I. PROTEIN—10 GR.
Example No. 1.

Breakfast	
Bacon	25 g.
Bran agar biscuit	(1)
Orange	½
Butter	10 g.
Coffee	1 cup

Example No. 2.

Breakfast	
Scrambled eggs (egg yolks only)	50 g.
Bran agar biscuit	(1)
Butter	5 g.
Coffee	1 cup

II. PROTEIN—28 GR.
Example No. 1.

Breakfast	
Bacon	50 g.
Bran biscuit	(1)
Butter	10 g.
Coffee	1 cup

Example No. 2.

Breakfast	
Fried egg	
Egg	(1)
Butter	10 g.
Bran agar biscuit	(1)
Butter	5 g.
Coffee	1 cup

III. PROTEIN—45 GR.
Example No. 1.

Breakfast	
Egg	(1)
Bacon	25 g.
Orange	½
Bran agar biscuit	(1)
Butter	15 g.
Coffee	1 cup

FAT—90 GRAMS.

Dinner	
Diabetic broth	
Bacon	25 g.
Lettuce	20 g.
Mayonnaise	1 T.
Cucumbers	50 g.
Salt and vinegar	
Extract agar—no food value	

Dinner	
Bacon	30 g.
Lettuce	20 g.
Cucumbers	50 g.
French dressing	
Oil	1 T.
Vinegar, salt, pepper	
Bran agar biscuit	(1)
Butter	5 g.
Watermelon E. P.	100 g.

FAT—140 GRAMS.

Dinner	
Watermelon cocktail	
Watermelon	100 g.
Pork chop	100 g.
String beans	100 g.
Butter	5 g.
Bran biscuit	(1)
Butter	5 g.
Ice cream	
Cream (18%)	100 c.c.
Vanilla	
Saccharine tablet	

Dinner	
Roast (beef)	50 g.
Lettuce	20 g.
Mayonnaise	2 T.
Bran biscuit	(1)
Butter	10 g.
Baked custard	
Cream (18%)	100 c.c.
Egg	(1)
Vanilla	
Saccharine tab.	(1)
Tea or coffee	

FAT—170 GRAMS

Dinner	
Diabetic broth	
Chop (pork)	100 g.
Turnips	100 g.
Butter	10 g.
Asparagus	100 g.
Mayonnaise	1½ T.
Bran biscuit	(1)
Butter	5 g.
Lemon snow	
Gelatin	5 g.
Lemon juice	10 c.c.
Egg white	(1)
Saccharine tab.	(1)

CHO—15 GRAMS.

Supper	
Diabetic broth	
Lettuce	20 g.
Mayonnaise	1 T.
Beets	50 g.
Butter	10 g.
Rhubarb sauce (100 g. before cooking, one saccharine tablet)	

Supper	
Diabetic broth	
Combination salad	
Celery	10 g.
Cabbage	20 g.
Onion	10 g.
Agar-Agar	1 g.
Water	100 c.c.
Salt, vinegar, ¼ saccharine tablet	
Mayonnaise	2 T.
Tomatoes canned	100 g.
Bran biscuit	(1)
Butter	5 g.
Tea or coffee	

CHO—20 GRAMS.

Supper	
Diabetic broth	
Mayonnaise	2 T.
Cucumbers	50 g.
Asparagus	100 g.
Extract agar with Logan berries	50 g.
Tea	

Supper	
Diabetic broth	
Cauliflower	100 g.
Butter	10 g.
Bran biscuit	(1)
Butter	10 g.
Bavarian cream	
Orange	50 g.
Agar-agar	1 g.
Cream (18%)	100 c.c.
Tea or coffee	

CHO—25-30 GRAMS

Supper	
Bacon	25 g.
Tomatoes	100 g.
Butter	5 g.
Cabbage	100 g.
Mayonnaise	1½ T.
Bran egg muffin	(1)
Butter	10 g.
Tea or coffee	

1. The Use of a High Fat Diet in the Treatment of Diabetes Mellitus. L. H. Newburgh, M.D., and Philip Marsh, M.D.: Archives of Internal Medicine, December, 1920, p. 647.

Example No. 2.

Breakfast		Dinner		Supper	
Poached eggs	(2)	Diabetic broth		Bacon	50 g.
Bran agar biscuit	(1)	Pork chop	120 g.	Cabbage	100 g.
Coffee	1 cup	Lettuce	20 g.	Mayonnaise	1½ T.
		Cucumbers	50 g.	Peaches	100 g.
		Mayonnaise	1½ T.	Cream	100 c.c.
		Junket		Tea or coffee	
		Cream (18%)	100 c.c.		
		Rennin			
		Saccharine tablet	½		
		Vanilla			
		Coffee			

The diet for each patient is calculated daily because the food supply varies in kind and quantities. J. Locke's "Food Values" is used for the computation work.

The following suggestions, which can be made with a limited variety of food supplies, may be useful to persons situated under like conditions. Custards, junkets, ice cream (18 per cent cream), jello and gelatine desserts, agar-agar (1 g. to 100 c.c.), whips, meat salads, egg salads, vegetable and fruit salads, fruit cocktails, soufflés, cream soups, are just a few of the many varieties one can make. Agar-agar may be used in every place that gelatin would be used without adding to the food value. It is cooked in the same manner as is done for bacteriological work.

Certain Foods Raise Fat Content

It is not difficult to make up this high fat diet if certain foods are kept in mind. The following foods are good ones when one must raise the fat content: bacon, cream, mayonnaise, French dressing, butter, pork, egg yolks, cheese, and beefsteak. For carbohydrate tolerance a greater quantity can be served if the lowest 5 per cent and 10 per cent fruits and vegetables are given rather than ones with more food value. Celery, rhubarb, watermelon, lettuce, cucumbers, green onions (20-30 gram serving), spinach, string beans, and asparagus are examples. The protein tolerance does not take as much adjustment as the other two tolerances when one is planning the diet.

There are two other difficulties often met in special diet work in this hospital. One is the patient with either no teeth or teeth in poor condition. A diet suitable for an ordinary diabetic cannot be served to this type of patient. There are certain foods which must be avoided in planning his menus. While the person can often eat a pork chop, he has difficulty with bacon, celery, lettuce, raw cabbage, cucumbers, radishes, and onions. Shredded lettuce and chopped cabbage he cannot eat and refuses them even when prepared with salad dressing. Cooked vegetables, which have been puréed, chopped fine, or made into cream soups, he relishes. He rarely has difficulty with chopped meat.

The other difficulty is that of religious faith. To the foreign born, especially the orthodox Jew, religion means a great deal. In the case of a Jewish patient, he refuses all forms of pork. Pork in some form is relied upon often to raise the fat content and to give variety in the form of meat to the diet. To win the cooperation of the patient, the dietitian must aid the doctor by adjusting her menus to meet this feeling. However, these difficulties only spur one's imagination and originality and make each future diet problem more easy to handle than before.

This Newburgh diet is at present a popular one in the Cook County Hospital. From the diet kitchen standpoint it is an easy diet to plan. One can get variety with a very limited supply of food from which to choose. However, there has not yet been a sufficient number of cases tried here on this diet from which to secure sufficient data to prove how adequate this diet is in the treatment of diabetes. Only further experimentation can prove the success of this treatment over those of the past.

AMERICAN DIETETIC ASSOCIATION MEETING DRAWS NEAR

You all know about the meeting of the American Dietetic Association, but perhaps you do not realize that time is rapidly passing and you should be making your definite preparations to spend October 24, 25, and 26 in Chicago. The trip would be a pleasant as well as an instructive part of your vacation.

An excellent program is assured by the fact that Miss Emma Gunther of Teachers College has it in charge. Each of the four sections will be responsible for one morning or afternoon session, a round table discussion, and part of an evening program.

The administrative section will present the results of the study which administrative dietitians have been asked to make, concerning equipment, supplies, food, wages, and morale of employees. This report made by the dietitians in charge of the Illinois, Michigan, Eastern, and Southern divisions will represent the very best opinion of trained dietitians. This section has been working under Miss Mary Lindsley, manager of the Grace Dodge Hotel, Washington, D. C.

The work done by the committees of the education section will be presented in condensed form. These committees have been dealing with the hospital training of the dietitian, graduate work for the dietitian, and the curriculum for teaching dietetics to nurses in training schools. This curriculum is being prepared at the request of the Association for Nursing Education, and will be discussed by representatives of that organization and the American Dietetic Association. This section has been under the direction of Dr. Ruth Wheeler, professor of nutrition in the Medical School of the University of Iowa.

The section on dietotherapy has been arranged by Miss Rena Eckman, University of Michigan Hospital, and will be a condensed report of the work done along these lines during the last three years. It will include recommendation as to the extent to which it is practicable to carry out these developments in hospitals and in other fields. Dr. Amy Daniels, Dr. Woodyatt, and other experts will speak on the subject.

The social features of the program are as alluring in their own way as are the intellectual ones. Among them are: a tea by the American Dietetic Association; a dinner meeting; trips to hospitals of interest, visits to hotels, restaurants, industrial cafeterias, etc.; a trip to the infant welfare stations; a trip to the University of Chicago commons; a luncheon at the Chicago Beach Hotel.

This is the time to make your plans to come.

Below is a schedule of rates given by Chicago hotels to members of the American Dietetic Association. If you have not made reservation, you should do so at once.

HOTEL LA SALLE.			
One Person—			
Room without bath	$2.50	$3.00	$4.00
Room with bath	5.00	6.00	7.00
Two Persons—			
Room without bath	$4.00	$4.50	$6.00
Room with bath	7.00	8.00	10.00
DRAKE HOTEL.			
One Person—			
Room with bath	$6.00	$7.00	$8.00
Two Persons—			
Two beds with bath	$8.00	$14.00	
Two single rooms with bath between are $10 per day for the two rooms.			
HOTEL BLACKSTONE.			
One Person—			
Room with bath	$5.00	$6.00	$8.00
Two Persons—			
Double bed with bath	6.00	8.00	10.00
Two beds with bath	12.00	15.00	16.00
Two single rooms with bath between are $12 per day for the two rooms.			
HOTEL SHERMAN.			
Single room without bath	$2.50—	$ 3.00	
Single room with bath	3.50—	6.00	
Double room without bath	4.00		
Double room with bath	5.00—	10.00	
Two connecting rooms with bath			
Two persons	6.50—	10.00	
Three persons	8.00—	12.00	

Four persons ..... 9.00— 16.00

HOTEL ALEXANDRIA.
Single room with bath. .....$2.00 and up
Double room with bath. ..... 3.00 and up

CONGRESS HOTEL.
Single room without bath but with running water..$3.00 per day
Single room with bath.....$5 00 per day and up
The above double rates on rooms mentioned are $5.00, $6.00, and $7.00 per day.
Rooms with two beds and bath range from $8.00 per day and up.
Lake front rooms are $10 per day, single, and $12 per day double.

VIRGINIA HOTEL.
Single room with bath.....$3.00
Double room with bath..... 4.50
Two and three-room suites for four or six people—$2.00 per day per person.

DEHYDRATED BUTTERMILK

Buttermilk is the residual milk left after churning, the fat having been removed. It forms a capital beverage as it allays thirst most effectively. Buttermilk is extensively used by the peasantry of some European and Asiatic countries. It must of necessity be ingested while cool and fresh as it rapidly decomposes and becomes rancid. Its action is diuretic to most individuals and it is unfortunate that most of it is fed to swine rather than being utilized by the human race.

An analysis of fresh buttermilk reveals 4.1 per cent nitrogenous matter; 0.7 per cent fatty matter (which is less than is found in skimmed milk); 6.4 per cent lactine; 0.8 per cent saline matter and water to the extent of 88.0 per cent.

Dietitians serve it freely to patients in hospitals, and in roentgenologic work it is generally agreed that buttermilk is the ideal medium for carrying bismuth or barium sulphate in suspension. It is not feasible to even attempt to have an adequate supply of fresh buttermilk always on hand, and of course, in roentgenologic work it is frequently required unexpectedly. To meet these very requirements, scientists and roentgenologists have made extensive experiments and have found that buttermilk in a dehydrated form is satisfactory, none of its virtues being impaired by subjection to that process. Just as the buttermilk comes from the churn it is dehydrated. The water is expressed from the product but nothing is added to the buttermilk solids thus obtained. When it is intended to be used, water is added to the dry product and you have fresh buttermilk again.

This pan-dried buttermilk is highly recommended as it permanently retains its properties, whereas in the natural state it deteriorates very quickly. It is not prone to absorb moisture, and it has been found to remain uninjured at a low temperature. Where there is an unusual amount of humidity present, it may cake if not kept carefully, but a little crushing in a mortar renders it normal and ready for use.

A ten-pound container of the dry product is said to produce forty quarts of buttermilk.

NEWS ITEMS

Miss Mabel Little spent the summer at her home in Ohio after giving up the work she was doing in Marshall Field's tearoom, Chicago. The coming year Miss Little will give a course in institution management at Madison, Wis.

Miss Naomi Jones resigned her position as assistant dietitian at Michael Reese Hospital, Chicago, and is taking a few months' vacation at her home in New York.

Miss Louise Stevenson, who has been dietitian at the St. Louis City Hospital for some time, has taken charge of the Town Club of St. Louis.

Miss Louise Keegan has accepted a position as dietitian of Meriden Hospital, Meriden, Conn.

All dietitians regret that Miss Charlotte Addison, formerly dietitian at Post Graduate Hospital, New York, has not regained her health sufficiently to resume work. She has been at Lafontaine, Ontario, for some time.

Miss May Foley was forced to take a long vacation on account of her health. She is back at the Mayo Clinic after having spent several weeks at her home in Worcester, Mass.

Miss Sue Coffin, formerly dietitian at Barnes Hospital, St. Louis, has resigned and has been at home in Itasso, Texas, during the summer.

Other dietitians who have changed their work recently now have addresses as follows: Eva Thallman, chief dietitian at Massachusetts General Hospital, Boston, Mass.; Mary L. Rhoades, Coatesville Hospital, Coatesville, Pa.; Florence Nolan, University Hospital, Baltimore, Md.; Elna Becker, University of Chicago, Chicago, Ill.; Mayme Lewis, Robert W. Long Hospital, Indianapolis, Ind.; Josephine Holman, previously at Greenville City Hospital, Greenville, S. C., is at her home in Atlanta, Ga.

A course in problems of the administrative dietitian was given in the summer session at Teachers College under the direction of Rena Eckman and Eleanor Wells.

Graduates of the home economics department of Cornell University who specialized in training for dietitians are taking student training as follows: Margaret Campbell, Hahnemann Hospital, Rochester, July appointment; Helen March, the same, September appointment; Mercy Walker, Jefferson Hospital, Philadelphia; Marcia Schenck, Lakeside Hospital, Cleveland; Elizabeth Cooper, New York City Hospital; Agnes Fowler, A. I. C. P., New York City, with Miss Lucy Gillette; Miss Ruby Odell of this class, who had previously had hospital training, is dietitian at the Corning City Hospital.

The Chicago Dietetic Association held its June meeting at the Nurses' Club on Friday evening, the twenty-fourth. Dr. Julius Hess gave a very interesting and practical talk on "Infant Feeding." At the July meeting, held at the Hospital Library and Service Bureau, July 15, Mr. Smith and Miss Little of Marshall Field tearooms led a discussion of institutional equipment, and the recent exhibits shown at the hotel men's show. A great deal was learned from this discussion concerning the merits of new equipment.

PELLAGRA AND INCOME VARY INVERSELY

That pellagra varies inversely with the family income in the cotton mill villages of South Carolina is the conclusion drawn after a three-year study by the United States Public Health Service. This is the first reported study in which the long-suspected relation of poverty and pellagra is definitely measured. As the income fell the disease was found to increase and to affect, more and more, other members of the same family. As the income rose, the disease decreased and was rarely found in families that enjoyed the highest incomes, even though this highest was still quite low. Differences among families with the same incomes are attributed by the report to differences in the expenditures for food, intelligence of the housewife, and ownership of cows, gardens, etc. Differences among villages which were economically similar are attributed to differences in the availability and condition of food in local markets.

A recent statement by one of the largest life insurance companies in the United States indicates that the food standards of southern wage earners must have improved remarkably of late, for the death rate from pellagra has fallen from 6.7 per 100,000 in 1915, to 2.3 per 100,000 in 1919.

Hospital Equipment and Operation

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

THE PURCHASE OF MEATS ON SPECIFICATIONS*

THERE is no longer any question as to the advisability of purchasing all supplies upon a basis of adequate and definite written specifications. The problem is to work out specifications that are both adequate and definite, yet at the same time practicable and satisfactory to the trade.

The Cleveland Hospital Council has for some time past given the question of the purchasing of meats special attention, and the following specifications have been used by the twenty-two hospitals in this Council, practically without change for the past year. They have proven satisfactory and workable; therefore, a valuable aid in routine purchasing. A good and valid reason exists for each detail included.

These specifications can be filed with the dealers from whom frequent purchases of meats are made, with the understanding that all orders are given under the agreement that these specifications shall be complied with in every particular, and all the deliveries accepted can then be required to meet the specifications. These specifications and this arrangement have made the purchase of meats by Cleveland hospitals distinctly more satisfactory as a business procedure, and have distinctly improved the quality of meats furnished to the hospitals. Controversies are eliminated and poor meat can be returned routinely on a business instead of a complaint basis.

It is our recommendation that all hospitals not now purchasing meat on specifications institute this policy, using the following specifications. Hospitals now purchasing their meat supply on specifications may wish to compare these specifications with those now used by their institution.

General Specifications

All meats to be properly aged.

All supplies to be properly inspected according to government regulations, and to comply in every respect with all pure food laws.

Fresh meats of all descriptions to cover regulation cuts, and all weights specified are dressed weights.

Where the term "average" is used, 5 per cent over or under is the margin of difference.

All meats such as steaks, chops, roasts, or pot roasts, and other various cuts which are requested by the institutions, are to be cut from meat complying with the following specifications.

The institutions in ordering steaks and chops should specify the thickness which they desire them to be cut.

Beef to be from choice fat steers; carcass, minimum weight 600 pounds, maximum 700 pounds. Beef from bulls, stags and cows will not be accepted. All beef to be free from bruises.

Mutton to be from fresh, choice wethers or dry ewes; round carcass, minimum weight 50 pounds, maximum 65 pounds, without pelts.

Lamb to be from freshly slaughtered, yearling lambs, which break at the joint; carcass, minimum weight 32 pounds, maximum 40 pounds, without pelts.

Veal to be from good native or western dressed calves, freshly slaughtered; carcass, minimum weight 100 pounds, maximum 125 pounds, without pelts.

Veal, special, to be from native milk fed calves, freshly slaughtered; carcass, average weight 100 pounds.

Pork to be from young hogs; carcass, with head on, average weight 175 to 225 pounds.

Beef

Prime steer beef, straight sides, minimum weight 300 pounds, maximum 350 pounds.

Prime steer beef, hindquarters, minimum weight 130 pounds, maximum 155 pounds.

Prime steer beef, forequarters, minimum weight 150 pounds, maximum 180 pounds.

Prime steer beef, standard seven cut rib, i. e., from the second to the eighth, inclusive, from loin; ribs to be not over twelve inches long measured from chine bone to edge of plat, inside measurement; minimum weight 30 pounds, maximum 35 pounds.

Prime steer beef, short loins to be cut off at center of pin bone; flank off; kidney out; not over 3 pounds of suet to be left in loin; minimum weight 30 pounds, maximum 36 pounds.

Prime steer beef, sirloin butts, i. e., hip ends of full loin; split at pin bone; flank off; not to exceed 3 pounds of suet; minimum weight 30 pounds, maximum 36 pounds.

Prime steer beef, top rounds, minimum weight 20 pounds, maximum 25 pounds.

Prime steer beef, bottom rounds, minimum weight 20 pounds, maximum 25 pounds.

Prime steer beef chucks, regulation cut, first four ribs of carcass, including shoulder but not including brisket or shank, minimum weight 75 pounds, maximum 100 pounds.

Beef livers, small, light in color, minimum weight 6 pounds, maximum 10 lbs.

Lamb

Lamb, whole or side, carcass, minimum weight 32 pounds, maximum 40 pounds.

Lamb, hindquarters, average weight 9 pounds.

*This article comprises Bulletin No. 35 issued recently by the American Hospital Association to its institutional members.—Editor.

Legs of lamb, minimum weight 6 pounds, maximum 7½ pounds.

Lamb, forequarters, average weight 10 pounds.

Lamb double racks, nine rib cut, i. e., from the second to the tenth rib, inclusive, from the loin, shoulder blades out, ribs to measure not over seven inches from chine; average weight 6 pounds.

Lamb single racks, nine rib cut, as above described, average weight 3 pounds.

Veal

Standard veal, whole or side; carcass, minimum weight 100 pounds, maximum 125 pounds.

Standard veal hindquarters, average weight 25 pounds.

Standard veal, forequarters, average weight 28 to 30 pounds.

Standard veal, legs, cut full without loins; average weight 20 to 25 pounds.

Livers, minimum weight 2 pounds, maximum 3 pounds.

Pork

Pork, whole or side; carcass, average weight 175 to 225 pounds.

No. 1 Pork loins, fresh, local dressed, close trimmed; minimum weight 8 pounds, maximum 10 pounds.

Hams, sugar cured, first quality, such as Armour's Star, Theuer-Norton's Paramount, Cleveland Provision's, Wiltshire, or Swift's Premium; weight 10 to 12 pounds, unwrapped.

Bacon, sugar cured, first quality, such as Armour's Star, Theurer-Norton's Paramount, Cleveland Provision's, Wiltshire, or Swift's Premium; weight 6 to 8 pounds, unwrapped.

Bacon, standard of the second grade of the various packers, weight 8 to 11 pounds, unwrapped.

Lard in 60 pound tubs, quality such as Armour's Shield, Swift's Silver Leaf, Theuer-Norton's, or Cleveland Provision's.

Chicken

Fowl should be fresh dressed yearling chickens; average weight 4 to 5 pounds.

Roasting chickens should be fresh dressed spring chickens; average weight 3½ to 5 pounds.

At times it will be necessary to purchase frozen roasting chickens, as there are seasons of the year when fresh roasting chickens are not available.

HOW TO PURCHASE CANNED FRUITS*

CANNED fruits should invariably be purchased by hospitals through the securing of bids on definite specifications as to quality. It is not sufficient to specify brands. The following specifications for canned fruits were submitted to and checked by the inspection service of the National Canners Association, July 1, 1921. They include certain figures published by the United States Department of Agriculture for testing the quality of canned fruits, and also the specifications adopted by the inspection service or educational committee of the National Canners Association. It is, therefore, possible for jobbers to supply all canned fruits complying exactly with these specifications, which fact commends them for general use.

Often the goods are sold by the jobbers under their own labels before being purchased by them or packed. Their purchases are made to fit their sales as to price as well as to quality. Suitable labels are prepared to meet the situation. Under these conditions advance orders are not a protection to the hospital in any way. The hospital carries all the risk of fluctuations in labor cost and fruit variations, and the adjustment is made in the quality of the contents of the can.

This is possible only through lack of definite specifications in purchase, and is aided by an unwise attitude on the part of the hospital purchasing agent who asks only indefinite and meaningless questions as to standards of quality but is very exacting and demanding as to price.

The above described situation is not desired by canners. It is better to produce uniform standardized packs with variation in price from year to year instead of uniform or arbitrarily set prices with variation in pack. The solution has been the establishment of standard specifications covering a sufficient number of grades to meet all conditions. This policy is now becoming more general, and while it was unquestionably initiated by canners for their own interest, it is, perhaps, even more valuable to consumers, and especially to the hospital.

*This article comprises Bulletin No. 36 (to be substituted for Bulletin No. 4), issued by the American Hospital Association to its institutional members, on standards and specifications for canned fruits. The detailed specifications which appear in this article were published on pp. 85 and 86 of the 1920 Edition of the Modern Hospital Year Book. They are reprinted here, however, for the convenience of the superintendents of those hospitals who have placed the Year Book on the desk of their purchasing agent for ready reference.

General Description of Standardized Grades

All of the following distinctions between grades should be carefully studied before the determination of the grades to be purchased.

The difference between fancy, choice, and standard quality in many canned fruits is chiefly found in the appearance of the fruit and the degree of the syrup, i.e., the proportion of sugar added. The fruit itself is often sorted at the cannery so that the very largest, most uniform, and finest appearing fruits go into the fancy grade, while those which are smaller and more or less irregular in form, and those which have been carelessly cut and trimmed go into the lower grades. The canner places a heavier syrup on the fancy grade because it is specially prepared for table use and commands a superior price. The choice or standard grades will often be better suited to the taste of many people by the addition of sugar a few hours before serving.

Superlative Quality. The top grade to be designated "Fancy."

Fine Quality..... The grade between the top and the middle to be designated "Choice."

Good Quality..... The middle grade to be designated "Standard."

Second Quality.....The grade between the middle and the bottom; fruit packed in 10% syrup to be designated "Second." Fruit packed in water to be designated "Water."

Pie Quality.....The bottom grade to be designated "Pie."

Either the Brix or Ballings Scale is used on hydrometers or saccharometers to indicate the percentage by weight of sugar going into the solution, the terms "percentage" and "degree" being synonymous when using these instruments.

It is to be understood in connection with the system of nomenclature herein adopted that the grades of the different varieties of fruits are to follow, as closely as is practicable, these general specifications, together with the detailed specifications for each grade and variety.

The same specifications as to quality of grade apply to cans larger and smaller than number two and one-half.

The size of the fruit in each grade is the same or larger for the larger cans as for the number two and one-half cans, and the same or smaller for the smaller cans as for the number two and one-half cans.

APRICOTS—

Grade	Count Pieces per No. 2½ Can	Syrup % of sugar when packed	Description
Fancy	24 or less. No single parcel should vary more than 6 pieces per can.	55	Fruit to be of very high color, ripe yet retaining its form and free from blemishes, halves uniform in size and very symmetrical.
Choice	30 or less. No single parcel should vary more than 7 pieces per can.	40	Fruit to be of high color, ripe yet retaining its form and free from blemishes, halves uniform in size and symmetrical.
Standard	42 or less. No single parcel should vary more than 8 pieces per can.	25	Fruit to be of reasonably good color and reasonably free from blemishes, halves reasonably uniform in size, color and degree of ripeness, and reasonably symmetrical.
Second	No size limits.	10	Fruit to be tolerably free from blemishes, halves tolerably uniform in size, color and degree of ripeness.
Pie	No size limits.	0	Wholesome fruit unsuited for above grades.

PEARS—

Fancy	Not less than 6, not more than 12 pieces. No single parcel should vary more than 4 pieces per can.	40	Fruit to be of very high color, ripe yet not mushy and free from blemishes, halves uniform in size and very symmetrical.
Choice	Not less than 6, not more than 15 pieces. No single parcel should vary more than 5 pieces per can.	30	Fruit to be of fine color, ripe yet not mushy and free from blemishes, halves uniform in size and symmetrical.
Standard	Not less than 6, not more than 21 pieces. No single parcel should vary more than 6 pieces per can.	20	Fruit to be of reasonably good color, ripe and yet not mushy, and reasonably free from blemishes, halves reasonably uniform in size and reasonably symmetrical.
Second	No size limits.	10	Fruit to be tolerably free from blemishes and tolerably uniform in size.
Pie	No size limits.	0	Wholesome fruit unsuited for above grades.

NEW CLING PEACHES—

Fancy	Not less than 6, not more than 12 pieces. No single parcel should vary more than 4 pieces per can.	55	Fruit to be of very high color, ripe yet not mushy and free from blemishes, halves uniform in size and very symmetrical.
Choice	Not less than 6, not more than 15 pieces. No single parcel should vary more than 5 pieces per can.	40	Fruit to be of high color, ripe yet not mushy and free from blemishes, halves uniform in size and symmetrical.
Standard	Not less than 6, not more than 21 pieces. No single parcel should vary more than 6 pieces per can.	25	Fruit to be of reasonably good color and reasonably free from blemishes, halves reasonably uniform in size, color and degree of ripeness, and reasonably symmetrical.
Second	No size limits.	10	Fruit to be tolerably free from blemishes, halves tolerably uniform in size, color and degree of ripeness.
Pie	No size limits.	0	Wholesome fruit unsuited for above grades.

YELLOW FREE PEACHES—

Fancy	Not less than 6, not more than 12 pieces. No single parcel should vary more than 4 pieces per can.	55	Fruit to be of very high color, ripe yet retaining its form and free from blemishes, halves uniform in size and very symmetrical.
Choice	Not less than 6, not more than 15 pieces. No single parcel should vary more than 5 pieces per can.	40	Fruit to be of high color, ripe yet retaining its form and free from blemishes, halves uniform in size and symmetrical.
Standard	Not less than 6, not more than 21 pieces. No single parcel should vary more than 6 pieces per can.	25	Fruit to be of reasonably good color and reasonably free from blemishes, halves reasonably uniform in size, color and degree of ripeness, and reasonably symmetrical.
Second	No size limits.	10	Fruit to be tolerably free from blemishes, halves tolerably uniform in size, color and degree of ripeness.
Pie	No size limits.	0	Wholesome fruit unsuited for above grades.

SLICED PEACHES—

Fancy		55	Fruit to be of very high color, ripe yet not mushy and free from blemishes, slices uniform in size and very symmetrical.
Choice		40	Fruit to be of high color, ripe yet not mushy and free from blemishes, slices uniform in size and symmetrical.
Standard		25	Fruit to be of reasonably good color and reasonably free from blemishes, slices reasonably uniform in size, color and degree of ripeness and reasonably symmetrical.
Second		10	Fruit to be tolerably free from blemishes, slices tolerably uniform in size, color and degree of ripeness.
Pie		0	Wholesome fruit unsuited for above grades.

CALIFORNIA BLACK CHERRIES AND WHITE CHERRIES—

Grade	Maximum Number Cherries per No. 2½ Can		Description
Fancy	100	40	Fruit to be of very fine quality, ripe, free from blemishes, and uniform in size.
Choice	125	30	Fruit to be of fine quality, ripe, free from blemishes, and uniform in size.
Standard	175	20	Fruit to be of good quality, reasonably free from blemishes, and reasonably uniform in size and degree of ripeness.
Second	No size limits.	10	Fruit to be tolerably free from blemishes and tolerably uniform in size.
Pie	No size limits.	0	Wholesome fruit unsuited for above grades.

R. A. CHERRIES—

Fancy	85	40	Fruit to be of very fine quality, free from blemishes and uniform in size.
Choice	105	30	Fruit to be of fine quality, free from blemishes and uniform in size.
Standard	145	20	Fruit to be of good quality, reasonably free from blemishes and reasonably uniform in size.
Second	No size limits.	10	Fruit to be tolerably free from blemishes and tolerably uniform in size.
Pie	No size limits.	0	Wholesome fruit unsuited for above grades.

PLUMS—

Fancy		55	Fruit to be of very fine quality, free from blemishes, and uniform in size.
Choice		40	Fruit to be of fine quality, free from blemishes and uniform in size.
Standard		25	Fruit to be of good quality, reasonably free from blemishes, and reasonably uniform in size.
Second		10	Fruit to be tolerably free from blemishes and tolerably uniform in size.
Pie		0	Wholesome fruit unsuited for above grades.

In the above tables the variation in size of fruit is excessive for a given year. It was so drawn to allow for the variation of different years.

Weight of Drained Contents of Cans

The United States Department of Agriculture has determined and published the proper minimum weights of the drained contents of a properly filled can of the following fruits.

For determination of drained weight the contents of number two and one-half cans and cans of smaller size should be emptied on a circular one-eighth inch mesh screen, eight inches in diameter, set in a frame with a vertical side higher than the level of the product on the screen. The contents of the can should be distributed over the screen so as to form a layer of uniform depth, this being accomplished so far as possible by the manner of emptying from the can. Such further handling as is required to level the material on the screen, so as to secure a layer of practically uniform depth, should be done in such a way as to exert no pressure whereby additional amounts of liquor will be expressed from the material. The period of draining should be two minutes in all cases. The manner of determining the drained weight for number ten cans is the same as the foregoing, with the exception that a circular one-eighth inch mesh screen, twelve inches in diameter, is used. This screen should also be set in a frame with a vertical side higher than the level of the product on the screen.

Fruit	Size of Can	Weight	
Unpitted Cherries.	2⅛	18 oz.	Syrup cutting out 20° Brix or above.
		19 oz.	Syrup cutting out below 20° Brix.
Unpitted Cherries.	10	68 oz.	Syrup cutting out 20° Brix or above.
		72 oz.	Syrup cutting out below 20° Brix.
Pitted Cherries	2½	18.5 oz.	Syrup cutting out 20° Brix or above.
Pitted Cherries	10	19.5 oz.	Syrup cutting out below 20° Brix.
		70 oz.	Water or juice pack.
Peaches	2½	20 oz.	
Peaches	10	68 oz.	
Pears	2½	19 oz.	
Pears	10	67 oz.	

The proper minimum weights of other fruits have not as yet been determined.

Hawaiian Pineapple

Hawaiian pineapple will be packed this season under the following specifications. All grades eight slices per can of No. 2 or 2½ sizes:

Extra Grade.—Fruit carefully selected and preferably of the yellow variety all slices carefully trimmed to remove remainder of eyes. Syrup test 25-26 degrees, Ballings Scale after draining one minute.

Standard Grade.—Uneven but unbroken slices sorted from the Extra Grade are used. Syrup 21-22 degrees Ballings Scale.

Broken Slices.—Broken slices used but packed so arranged as to look like whole slices. Syrup 22 degrees Ballings Scale.

Crushed and *Graded* in No. 10 Tins—Fruit crushed and graded. All eyes, black specks are eliminated, making a clean product. Syrup as follows: Extra Grade 25-26 degrees Ballings Scale.

Standard Grade.—21-26 degrees Ballings Scale.

Juice Grade.—No syrup degrees Ballings Scale.

If you desire sliced pineapple in number ten cans you can use the above specifications excepting the number of slices per can.

TO OPEN METHODIST HOSPITAL, MEMPHIS

The first unit of the new Methodist Hospital, Memphis, Tenn., will be opened early in October. The building is modern in every respect and contains 102 rooms. There are no wards and twenty-four of the private rooms have baths in connection. There are five operating rooms, equipped as are those of the Mayo Clinic, and finished in green tile with gray tile floor, giving a very pleasing effect. When all the units are completed the capacity of the institution will be 550 beds.

Occupational Therapy and Rehabilitation

Conducted by HERBERT J. HALL, M.D., President, National Society for the Promotion of Occupational Therapy, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
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VOCATIONAL TRAINING OF TUBERCULOUS PATIENTS

BY MRS. CLYDE M. MYERS, SECRETARY, VOCATIONAL TRAINING, NEW YORK TUBERCULOSIS ASSOCIATION, NEW YORK CITY

"TO PUT the consumptive back on the job," as a New York paper expressed it, is one part of the work that the New York Tuberculosis Association proposes to do.

The plan is to maintain as a part of its information bureau, an application bureau, where by means of medical examination and sociological investigation, applicants for reconstruction can be classified according to their needs, and properly advised. Those needing employment only, will be referred to the employment bureau; those in good physical condition, but without a trade, to the workshop for industrial rehabilitation in New York City; those needing treatment and suitable for training, to one of the affiliated sanatoriums, and finally, those unsuitable because of severe illness, or for other reasons, to hospitals or clinics for home care.

The order in which the Association is proceeding to put into operation its plans, is, one might say "from the outside, in," as the first step was to make a survey of various industries in New York City, to find the trades best suited from every standpoint, for the establishment of a workshop for the training and industrial rehabilitation of arrested cases of tuberculosis.

The result of this survey was the selection of three industries, namely, watch repairing, jewelry making, and fine cabinet work, or the repairing of high grade furniture.

In New York City a loft was secured, with a floor space of 7,000 square feet, lighted and ventilated from every side, an ideal place for the model workshop which was opened in June, splendidly equipped for the training of the men. The instructors are among the most competent that could be engaged in this country to teach the trades.

A dining room is provided where luncheons are served at cost.

A doctor prescribes the hours of work for each patient and a nurse sees that his orders are enforced.

A few of the several reasons why these industries were chosen are because:

(1) There are no objectionable health features; (2) There is a large demand for trained men in the small shops and factories; (3) A long apprenticeship is not required before a man will begin to earn money; (4) The wages are exceedingly good; and (5) in all of these trades there is the opportunity, in almost any locality, for a man to have his own small shop without a large investment of capital.

Another important reason for the selection of these three industries for the workshop, was because preliminary vocational training can be given in the sanatoriums in the vicinity of New York, with which the New York Tuberculosis Association is cooperating.

The training in the affiliated sanatoriums has been started so very recently that little can be said of it, except of the general plan for the work.

At each point, the workshop has been equipped for specific training in jewelry making and wood working.

The training in watch repairing will be given only at the Gaylord Farm Sanatorium in Connecticut, which is in the vicinity of the large clock and watch making industries, and is near the homes of many of the patients.

Quite naturally there will be patients in the sanatoriums who are not interested or fitted for the trades taught in the workshop for industrial rehabilitation. To some, the instructors will give work for its therapeutic value only. To others, who are in need of a graduated exercise to restore them to the normal condition necessary for the return to their former occupation, work will be given when possible, that will stimulate an interest and desire to "carry on," and that will be of value as a supplement to their profession, business or trade.

Elementary and high school work will be taught when needed, and commercial educational subjects combined with typewriting, stenography, and bookkeeping. These subjects are often of value to patients who wish to be self-supporting, and remain in a sanatorium after they have recovered sufficiently to work, but are unable to return to their former living conditions. The training of patients as teachers for occupational work with the tuberculous is also being done. Some of the crafts that have a distinct commercial value, and when the product can be sterilized, will be taught to both men and women whose stay in the sanatorium will be of long duration. These crafts may not be of any great worth as a vocation for the outside world, but in the sanatorium, and perhaps later in the home, a saleable product can be made that will enable the patient to earn money.

The only way this will be possible, is by standardizing the work, the problem must be approached in the same order as was that of the workshop for industrial rehabilitation, that is, by first making a survey of the market, then learning the demand, probable sales price, and cost of each article, also the quickest and least expensive way of making and handling the product.

The articles for manufacture should first be made by an experienced designer and craft worker, and then made

in the sanatorium under the supervision of a competent and critical instructor, or a visiting instructor if in the home. This does not mean, of course, that the joy of creating new models will be denied the sanatoriums, in fact, a little friendly rivalry may be a stimulating thing, but a model will always have to be passed upon by the designer engaged for that purpose, before it becomes standardized and material and time are used for making it in quantities.

It should be added here that the greatest care has been used in the selection of instructors for the sanatoriums, and only those with an excellent personality and the most thorough training to be had in the schools of this country were accepted. The occupational therapist with a few months of training to his or her credit may succeed admirably in therapeutic work if possessed of a good personality, but to train a man or woman to do work of commercial or economic value, and which is not dependent upon the sympathy of the employer or buyer, is quite another thing. The additional expense of paying for the services of an experienced and thoroughly competent person is not only of the greatest economy in the end, but the only way in which it is possible to attain the success and high standards for which the New York Tuberculosis Association is striving, and which will be of the greatest value in helping to restore the tuberculous patient to industry.

The most careful medical records are being kept, and the Association will eventually publish a full and detailed report on the methods of procedure and the results obtained.

WHAT IS OCCUPATIONAL THERAPY?

At Keene's Chop House in New York City, on the sixteenth of June, nearly a hundred people, most of whom were attending the annual meeting of the American Tuberculosis Association, sat down to luncheon and the discussion of occupational therapy. Many short addresses were made by men prominent in the tuberculosis field. The interest centered upon the need of providing some kind of light, remunerative work for those in whom the progress of tuberculosis had been arrested, but who could not wisely for years, if ever, engage in the ordinary lines of work. This trend of interest at such a gathering caused one of the speakers to ask, quite naturally, "What is occupational therapy?" He had supposed the field a narrow one, that it was confined to the hospital and to those stages of early convalescence when the idle patient was given prescribed occupations for the purpose of developing initiative and self confidence. He had supposed, and rightly, that the most important element of the system lay in the accurate prescription, in the choice of work to fit the patient's limitations, and in the control of the amount of work performed, so that all good and no harm could come from the application. His idea, and it is the commonly accepted one, was that occupational therapy ends where vocational training and regular, or even regulated, industries begin.

It is possible that we should accept this limitation and be satisfied, but the writer believes that in years to come the scope of occupational therapy will be greatly widened. We have been cautious about the commercialization of the hospital occupations because we have seen instances of harm from over-work and over-production. We have wisely put therapeutics first, and at production we have been inclined to look askance. Whenever any of the leaders have shown enthusiasm for production, have talked of standardization in the work and the elimination of some of the useless handcrafts, there has been a cry of caution if not of sharp criticism. The conservatives have said, "It makes no difference what the patient manufactures, so long as his hands and mind are kept wisely and constructively occupied." There is reason in this stand, though the probability is that time will show a change of opinion.

We may say, then, that occupational therapy is the art of prescribed work for the purpose of functional re-education after weakening illness, and that when the training is prolonged beyond this convalescent period we enter the domain of vocational training and the regular industries, where, to be sure, oversight and caution may be necessary, but where the approach and the method is altogether different.

But suppose we consider only the problem of arrested tuberculosis. Dr. Bayard T. Crane of Rutland, Mass., stated that about 70 per cent of the sanatorium cases would have to be looked upon as arrested, but not cured. In other words, the patients are liable to a return of the disease if they become careless, if they enter the ordinary competitive field of labor without supervision.

It looks as though work would have to be "prescribed" for this large class of people, if their ultimate relapse is to be avoided. The American Tuberculosis Association went so far as to pass at the June meeting, resolutions to the effect that it be one of the interests of that body to study the possibilities of specially protected industries for the arrested cases.

Somebody must assuredly be on guard for these people. Who is better able to control their work problem than the occupational aide who has watched the progress of the patient during convalescence, who has the patient's confidence, who knows the reaction of the individual to the factor of physical exertion? Surely the doctors will be glad of some such cooperation in their difficult task of supervision. Perhaps the definition of occupational therapy may have to be extended to include the supervision and control of the work of the handicapped.

The speakers at the luncheon were introduced by Mrs. Eleanor Clark Slagle. They were Lieutenant Colonel William Hart, Department of Soldiers' Civil Re-Establishment, Ottawa, Canada; Dr. T. W. Jackson, assistant director of the Department of Health, Harrisburg, Pa.; Mr. Bird S. Coler, commissioner of Public Welfare, City of New York; Dr. Robert J. Wilson, Willard Parker Hospital, New York City; Dr. Bayard T. Crane of Rutland, Mass.; Dr. Philip King Brown of San Francisco, Cal.; and Dr. Herbert J. Hall of Marblehead, Mass.

MAKE ARRANGEMENTS FOR ANNUAL MEETING IN BALTIMORE

This is the last number but one of THE MODERN HOSPITAL to appear before the annual meeting of the National Association for the Promotion of Occupational Therapy, in Baltimore. The meeting, as is well known, will be held at the Southern Hotel on October 20, 21, and 22.

Every occupational or physiotherapy aide, every social service worker or nurse, every doctor and hospital superintendent who is interested in the problem of reconstruction, and who can possibly manage to go to Baltimore for this meeting, should do so.

Occupational therapy is not only a local issue of first importance to the community, it has become a matter of national interest and concern. The subject will be discussed in all its bearings by people whose experience qualifies them to speak. There will be exhibitions of crafts work from hospitals and sanatoriums all over the country. Round table conferences will cover the special clinical fields.

For the aides who had their training together, or who served together in the A. E. F., but who have since been widely separated, it will be a delightful opportunity for reunion. The accumulated experiences of the year will be brought to Baltimore and told for the common good. Dr. William R. Dunton, who has the arrangements for the meeting in charge, promises that there will be plenty of entertainment and diversion besides the serious and technical program. Even if you have put off your decision until the last moment, it may be possible to secure reservations by writing at once to the Southern Hotel, Baltimore, Md. The rates follow:

ROOM RATES:

One Person

Shower baths, $4.00 to $4.50 per day.
Tub baths, $5.50 to $7.00 per day.

One Bed, Two Persons

Shower baths, $6.00 to $6.50 per day.
Tub baths, $7.50 to $9.00 per day.

Twin Beds, Two Persons

Shower baths, $7.00 to $8.00 per day.
Tub baths, $8.00 to $10.00 per day.

Connecting Rooms, Two or Three Persons

Shower baths, $11.50 per day.

Connecting Rooms, Two Persons

Tub baths, $11.00 per day. $2.50 additional per person.

Connecting Rooms, Three or Four Persons

Shower baths, $16.00 per day.
Tub baths, $17.00 per day.

Rates for parlor, bedrooms and baths upon application. Reservations held after 7 p. m. only upon definite and special request.

OCCUPATIONAL THERAPY AND LEPROSY

By ELSIE HASSENSTEIN, Cook County Hospital, Chicago, Ill.

At first thought leprosy would seem well outside the range of occupational therapy service, but apparently the solitude and despair of this terrible disease may be ameliorated at least to some extent by the use of prescribed work. The following communication from Chicago should be of the greatest interest to every occupational therapy aide and director. It would be good "copy" for the newspapers and periodicals. One point should be made clear; by observing ordinary precautions of cleanliness, the aide may easily avoid any danger of infection when dealing with these cases. Also, it is true that there need be no prejudice against the use of articles made by lepers; such fabrics as rugs, for instance, can be easily sterilized so that they become safer perhaps than the oriental rug that has received no such treatment.

The work described in this article sets us thinking; how about the leper colonies in their island exiles, what a splendid thing it would be to carry absorbing work to these desolate people. A sacrifice? Perhaps; but there are people who would like to go.—EDITOR.

The occupational therapy department at Cook County Hospital, Chicago, is taken care of by three paid workers and one regular volunteer worker. We have a large, sunny, well equipped shop, away from the wards, which allows us to have a victrola, and to make as much noise as is required in the construction of the larger woodwork. Our patients, who represent many nationalities, come up to the shop and are given work, as far as possible, that is most congenial to them.

As in every large general hospital, the average stay of a patient is about nineteen plus days, consequently our shop workers are constantly changing, with the exception of patients from the orthopedic wards, who are often here for a very extended period. We find that our shop people are very happy, and are at the doors early in the morning, and again at noon, for they realize that this is the only place in the hospital where they are absolutely free from all routine. We learn to know our patients very well and are able to help the social service in unraveling many of their knotty problems.

Our biggest piece of work, however, is done in the wards, at the bedside. We have calls from doctors and nurses throughout the hospital asking us to help a man or woman who is becoming very restless during a long convalescence, and who can't get into our bright shop.

Our patients become so much interested in their work that they often turn out very professional looking articles, for which there is a ready sale. After the cost of the materials has been deducted, the patients receive all money, thereby making it possible for them to have very many luxuries which they would otherwise be unable to obtain. In several long time cases, patients have opened bank accounts.

As all occupational therapists know, we have so many perplexing problems to solve that we are often at our wit's end to carry on, but perhaps the most perplexing of all problems at our hospital came to us when one of our physicians asked us to give work to a man who was afflicted with the old time dreaded disease, leprosy. It seemed that we could not handle this case, but we were finally persuaded to visit the man. We found him to be a Servian, intelligent, clean, with fine sensibilities, but shut up in one room for seven long months, with only the bare walls to look at. This isolation was making him nearly crazy. The physician assured us that there was nothing to fear in working with this man, so we finally gave him as his problem an oriental knotted rug, in which he immediately showed great interest, and which he made with such good workmanship that it was promptly sold for $50. In the second rug we planned a more complicated design, which made our patient even more interested in his problem, and we were able to sell this rug for $100. In the third rug, our patient was not content until he had worked out his own design. This gave him so much to occupy his mind and hands that he has very little time to think of his own affliction and is now happy and contented. He is also paying off a debt which he contracted at another hospital.

Since the time we were asked to take our Servian man, we have taken on work with a colored woman who is afflicted with the same disease. As her fingers had become quite stiff through disuse, we gave her the problem of braiding a rug of gay colored rags, and have been very much gratified, not only in her interest, but in the fact that she herself realizes the benefit she is obtaining from this work.

We feel, as occupational therapists, that our work is very much worth while, because it touches the human side of hospital life, and we are hoping that the day is not far off when we may have the privilege of bringing work, and consequently happiness, into every hospital and institute where our help is needed.

WOMEN'S CLUBS HAVE O. T. COMMITTEE

Mrs. Eleanor Clarke Slagle, executive director of the New York State Society for the Promotion of Occupational Therapy has been made chairman of the occupational therapy committee of the National Federation of Women's Clubs, and Mrs. Walter King Sharpe of Chambersburg, Pa., is to have charge of a similar department in the State Federation of Pennsylvania Women. The importance of such an association with the great organizations of women's clubs cannot be over estimated. It is through such support and understanding that occupational therapy is to find its most dependable support.

PHYSICAL THERAPEUTICS IN NEW YORK HOSPITALS

There was published in the April 30 issue of the *Medical Record* an important article on "Physical Therapeutics in New York Hospitals," by Dr. A. B. Hirsh, of New York. Dr. Hirsh points out a growing tendency on the part of the medical profession to add the so-called physical methods of treatment to the hospital equipment. In the past, the profession has had toward the subject of physiotherapy an attitude of indifference, sustained by the absence of the subject from the medical school curriculum. However, the author expresses satisfaction that this lack of interest is changing to a feeling of lively appreciation, as a realization of the wonderful possibilities in the treatment of disease by the use of physical means is being brought home.

Dr. Hirsh deplores the fact that "the chief obstacle now preventing a more rapid spread of knowledge in physiotherapy is the insufficient number of teaching courses available, either for the undergraduate or the full-fledged practitioner . . . Ultimately, hospital facilities must be at hand for the larger groups of physicians who are soon sure to find it necessary to add this knowledge to their other attainments. And for this end the hospitals of the metropolis, the main graduate teaching center of the country, must furnish the clinical and other needs." Dr. Hirsh in his visits to fifty hospitals throughout New York City is encouraged by the fact that of this number, five "were found to have fairly complete arrangements for physiotherapy." He hopes that with such a fair

Title of Hospital	Hydrotherapy: Massage	Correctional Exercises	Continuous Bath	Nauheim Bath	Shower, Etc., with Control Stand	Whirlpool for Arm	Whirlpool for Leg	Seat Bath	Plinth for Body Wrapping	Radiant Light & Heat-Electric: Cabinet for Entire Body	Half-Length Body Lamp	Quarter-Length Body Lamp	Hand Lamp	High Wattage Lamp	Solar Ray Lamp	Convective Heat Thermotherapy: Electric Baking: Body Length	Arm and Leg	Joint Size	Body Baker—Steam Radiator	Mechanotherapy: Bott Apparatus	McKenzie Apparatus	Bergonié Apparatus	Gymnasium	Tissue Oscillator	Electrical Vibrator	Zander Apparatus	Actinotherapy—Ultra Violet Ray	X-Ray: For Diagnosis	For Treatment	Radium	Electro-Therapy: Galvanism	Faradism—Bristow	Combined Galv. and Far.	Wall Plate	Galvanic Condenser	Galvanic Sinusoidal	Static Currents	High Frequency Currents	Morse Sine Wave	Electro-Coagulation	Electric Motor Suction Pump	Electrical Magnet	M. D. as Director of Phys.-Ther.	Coordination of P-T and other Depts	Non-Medical Person in Charge	New Building Planned with P-T Outfit	Plan Physical Therapy Outfit	Occupation Therapy
Memorial*																													+																		
U. S. Naval, Brooklyn, N. Y.*	+	+		+	+	+	+	+		+	+	+	+	+			+			+	+				+			+	+		+	+	+								+	+				+
New York Orthopedic	+	+																					+					+	+													+	+				+
U. S. P. H. S., Fox Hills, Staten Island, N. Y.*	+	+				+	+	+		+	+	+	+	+			+	+		+	+			+				+	+		+	+	+		+						+	+				
Community Hospital in the City of New York													+	+											+			+														+					+
Woman's																												+	+													+	+				
Roosevelt	+									+							+	+										+	+	+	+											+	+	+				
Sloan Maternity																																															
Vanderbilt Clinic					+			+		+													+		+									+												
New York Nursery and Child's		+											+																	+			+		+	+	+				+					
French			+		+																							+	+													+					
St. Vincent's	+																	+										+	+													+					
Hospital for Deformities and Joint Diseases*	+	+	+								+	+	+	+			+	+					+		+	+		+	+		+			+							+	+		+		
St. John's																																															
New York	+	+			+					+									+						+			+	+					+							+	+				
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People's					+					+																		+			+										+			+		
St. Elizabeth's																																															
Reconstruction	+	+	+		+	+	+	+		+	+	+	+	+	+		+	+		+	+				+		+	+			+	+	+	+	+		+			+	+		+		+
Booth Memorial																																															
St. Mark's	+										+		+																		+										+	+		+		
St. Mary's Free Hospital for Children																																															
Skin and Cancer			+	+	+			+																			+				+									+	+				
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Bellevue	+	+	+	+	+			+			+	+											+						+				+							+	+				
Lying-In																													+													+					
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Postgraduate	+	+	+		+				+	+	+		+				+	+								+	+	+	+	+	+	+		+	+	+					+	+				
St. Andrew's Convalescent																																															
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Woman's Infirmary																																															
Hospital for Ruptured and Crippled	+	+	+		+			+	+	+	+	+	+			+	+	+					+		+	+		+	+		+	+	+							+	+				
Columbus																													+													+					
Presbyterian	+	+	+		+					+	+	+	+		+														+													+					
Beth Israel*	+	+											+				+	+											+	+																	
Neurologic Institute	+	+	+		+					+			+		+	+	+	+							+	+			+	+	+	+	+	+	+						+					
St. Bartholomew's Clinic and Hospital	+	+	+		+																								+													+					
Mount Sinai*	+	+	+					+			+	+		+		+	+	+					+			+		+	+		+	+									+	+				
Hahnemann	+												+				+												+													+					
St. Luke's	+	+	+	+	+			+					+				+	+											+	+				+	+	+						+					
Sydenham																													+													+					
Polyclinic—U. S. P. H. S.*	+	+	+		+	+	+	+		+	+	+	+																+	+	+	+		+	+	+					+					
Beth David																													+													+					+
Montefiore	+	+	+	+	+																								+													+					
St. Ann's Maternity																																															+
Lenox Hill*	+	+	+	+	+			+		+	+	+	+																+													+					
New York Foundling																																															
Lincoln	+												+																																			
Broad Street*	+	+	+		+			+		+	+	+	+																+													+					
Fordham													+																																			
Manhattan State Hospital, Ward's Island*	+	+	+		+				+	+																			+													+	+				

*Information supplied by a member of the visiting staff. At other institutions above data was given and all apparatus shown the writer by either the superintendent or by an interne or member of the staff, at the request of the superintendent. The plus-mark signifies that the method printed at the head of the column is utilized by the hospital named at the left-hand end of the horizontal line.

start in this new direction, and by means of active propaganda, medical staffs and directorates in general may be made to realize "the urgent need for introducing these indispensable measures."

The table on p. 236 shows the results of Dr. Hirsh's investigation.

NEW PUBLICATIONS

The *P. T. Review* brought out its initial number in March and the second issue in June. The periodical is published by the American Women's Physical Therapeutic Association and the editorial staff is as follows: editor in chief, Elizabeth Huntington; assistant editor and advertising manager, Isabel H. Noble; assistant editor and business manager, Elizabeth L. Wells; news and A. E. F. editors, Inga Lohne and Ruth Earl; news editors, Emily Wellington, Hazel Furchgott, and Marion Sweetser; advertising assistant, Mattie Hindman; subscription manager, Marion Dawson; foreign correspondent, Josephine Bell.

The magazine is well printed and contains approximately twenty-four pages, including quite a little effective advertising matter. Judging from the text and general makeup, the physical therapeutic aides will have a publication worthy of the cause.

One wonders what will become of the *Re-Aides' Post* now reduced to quarterly appearance. Is the tie between physiotherapy and occupational therapy sufficient to support even a quarterly? It ought to be. The army service of these two groups was reciprocally fine and there must have been many lasting friendships formed which could be well served by a journal in common. On the other hand, occupational therapy and physiotherapy are in a sense distinct professions. Occupational therapy is developing rapidly and effectively; strong state societies are forming, and the national society has grown by leaps and bounds during the past year. Occupational therapy deserves a magazine of its own. Such a periodical could copy from the *P. T. Review* items and articles of occupational therapy interest, and the physical therapy journal might find occasion to keep its subscribers informed of occupational therapy doings.

We believe that the *Re-Aides' Post* is an indispensable tie between the two groups. It is well edited and deserves to live.

There is talk of a special occupational therapy journal, and room for it, perhaps. Meanwhile, THE MODERN HOSPITAL has served us well. We were promised four pages and have usually been allowed six. Whether the National Occupational Therapy Society decides upon a new journal or not, it is proposed to continue this section, for the very good reason that THE MODERN HOSPITAL goes where we want good, live occupational therapy news to go, right into the offices of hospital executives in all parts of the world.

Theoretically, it would be better for all reconstruction interests to unite in one journal like THE MODERN HOSPITAL, making a strong and inclusive section. Practically, the various departments may prove to have so much individual interest that special journals will be necessary.

Dated July 4, 1921, comes with a boom the first issue of the *Oteen Echo*, a six-page sheet full of snap and enthusiasm. It comes from United States Public Health Service Hospital No. 60, and is most creditable to the enterprise of its editors and contributors, whose names are not given. The contents of the first number is mostly local news, baseball games, and items of interest from the various wards, though there are more serious articles, notably one on the function of the hospital library.

The *Re-Aides' Post* for July shows no signs of diminished vitality. Miss Belva Guzzort, president of the National Society of Ex-Military Reconstruction Aides, in urging renewal of membership and support of the *Post*, says: "We find in the fee, a chance for saying individually that we pledge anew the original purposes of the association—to keep up friendship ties, to 'carry on' in civilian life the aide's achievement in army service, and to serve one another. . . . How can a small fee express so much? It pays for peculiar commodities—those intangible, yet real and lasting things awakened in the aide group, things of heart, things of vision."

FEDERAL BOARD ACTIVITIES IN REHABILITATION FOR TUBERCULOUS CASES

The Federal Board for Vocational Education has established in Nauvoo, Ill., a special school for the rehabilitation of ex-service men who have been discharged from tuberculosis sanatoriums as inactive cases. In describing this project in the *Vocational Summary* for February, 1921, Dr. John W. Turner makes telling statements which may be applied to other classes of handicapped, as well as the tuberculous: "For the tuberculous, rehabilitation means spiritual as well as physical or economic restoration, cultural as well as utilitarian attainments. It is more than soporific job placing. The rehabilitation training should be fundamental and efficient, and in accordance with the intellectual and physical capacity of the trainees."

It is recognized that the disability attributable to tuberculosis is dual in nature, mechanical in the damage to the lungs, and hazardous inasmuch as the inactive tuberculous case must be ever cautious of another breakdown until the condition of unstable equilibrium is passed. During his convalescence in the hospital, training suited to the patient's physical condition is given under medical supervision. When the purpose of this period of physical convalescence in the sanatorium is fulfilled he is still unable to function sufficiently well to carry a full course of study or to earn a livelihood. He needs a continuance of training under medical supervision until he has passed well along into industrial convalescence. Considering the physiological, pedagogical, and psychological aspects, a special school seems the logical solution of the problem.

"In short, the rationale of the special school is predicated on a profound knowledge of tuberculosis, its tendency to recur until it has been well stabilized by long periods of healing, an appreciation of the frailty of human nature and its need for medical guidance, and the favorable influence of a helpful environment."

The functions of the special school at Nauvoo are summed up as follows: "First: It prepares the tuberculous for real scientific vocational guidance, and fortifies him against a breakdown, by a course in physiology, hygiene, and job opportunities. Second: It adjusts the training to the man during the early critical period of his convalescence out of the hospital by providing the right environment and medical supervision. Third: Its purpose and function have been completed when the health of the trainee has been stabilized to the point where he can carry on with a more limited medical supervision."

NEW ENGLAND HOSPITAL AUTHORITIES TO MEET

The hospital authorities of New England are going to meet to determine the advisibility of forming a New England Section of the American Hospital Association. The meeting will be held at the Boston Medical Library on December 7, 1921. Dr. A. R. Warner executive secretary of the American Hospital Association will speak.

VENEREAL DISEASES AND THE HOSPITAL

Conducted by ALEC N. THOMSON, M.D.
Director, Department of Medical Activities
The American Social Hygiene Association, 105 W. Fortieth St.,
New York City

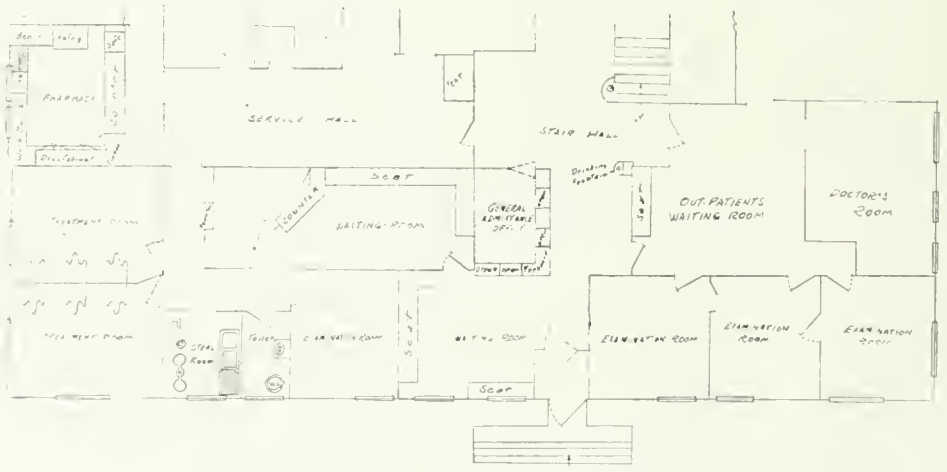
PUBLIC HEALTH SERVICE ESTABLISHES A MODERN VENEREAL DISEASE CLINIC

THE United States Public Health Service has taken over the old Hudson Street Hospital in New York City, and has renovated the entire building, establishing an excellently arranged and equipped in-patient and out-patient service for disabled veterans, merchant seamen, and other beneficiaries of the service. The hospital is administered by the Marine Hospital Division, U. S. Public Health Service. Venereal diseases are taken care of on the street-level floor by a division of service—dermatology, caring for syphilis; and urology, caring for gonorrhea. Unfortunately the institution is for the care of men only.

As the patient enters the building, he steps into a small waiting hall, which contains the general admittance office. This waiting room is merely a clearing station for distribution to the sub-waiting room connected with each clinic. The syphilis patients are cared for in a room to the right of the entrance and the gonorrhea patients in a room to the left of the entrance. The social service department has its offices on the same floor, adjoining the dermatological clinic, and uses the same waiting room. A male social worker is on duty in the venereal disease service. The floor plan shows the general arrangement.

In examining the urological suite, the first thing one notices is "a distinctive traffic lane" which obviates criss-crossing of patients. Following the patient through his course, we see him enter from the street, pass up to the general admission desk, register, step into the waiting room of the urological department, as his turn arrives step up to the counter and receive his case folder, go to the treatment or examination room, return to the small window, leave his record, get checked out by the male social worker, and pass into a hallway which leads back to the general admission desk. In this hallway he finds the drug counter, in case he has a prescription to be filled. The photograph of the waiting room shows these various points.

In the plan of the clinic two treatment rooms are provided. The first is intended for the relatively cleaner procedures of a urological clinic; the other for the handling of the active, infectious gonorrheal cases. The photograph of the clinic room does not show the arrangement of screens which are planned to separate the individuals. It is the intention of the hospital to place an extension of the swinging bracket type between the treatment stands; similarly, to screen the tables which are placed on the opposite side of the room, head toward the wall. It will thus be possible in a room eleven by fourteen, to handle patients with greater privacy than is usually observed in the average clinic treating five or six patients in one room at the same time.



Plan of Public Health Service Venereal Disease Clinic.

The one point to criticize is the lack of a separate his-

Waiting Room.

tory room where the professional histories may be carefully taken. It is hoped that the room now containing sterilizers may be so used.

The treatment of syphilis is carried on in a series of rooms easily adapted to the purposes of the venereal disease clinic. In general, it may be said that the new Hudson Street Hospital Clinic, conducted by the United States

Treatment Room.

Public Health Service, meets the requirements of privacy, ease of handling, and thoroughness of professional attention. It is hoped that this clinic will demonstrate some of the problems that have confronted clinic management for many years. The major problem which the Hudson Street Clinic can solve is the handling of a large number of venereal disease patients with the maximum of ease and comfort and the minimum of staff and expense.

PUBLIC HEALTH ACTIVITY AND PRIVATE PRACTICE IN VENEREAL DISEASE

By JOHN H. STOKES, M.D., Chief of the Section of Dermatology and Syphilology, Mayo Clinic, Rochester, Minn. The Journal of the American Medical Association. Vol. 76, No. 18, April 30, 1921.

A great, humanitarian public spirit is seeking, through public health officers, to wipe out a group of controllable infections—the venereal diseases. A large body of equally well intentioned private agents, in the form of the medical profession, derives its livelihood, at least in part, from the same source. An antagonism between the public activity and private interest, which might so easily develop in such a situation, would be wholly unnecessary and deplorable. The United States Public Health Service and the associated venereal disease divisions of various state boards of health realized the implications of their entry into this field of medical practice and submitted a declaration of principles and intentions, the summary of which is:

They indorse and urge the continuance of a campaign of public education.

They urge the evaluation of the propaganda thus far carried on in as exact social, psychologic, and medical terms as possible.

They prefer education and persuasion to legal process in regard to law enforcement and regulation.

They ask the intelligent and sympathetic cooperation of the medical profession. This cooperation can best be obtained by the rapid extension of specialized teaching facilities for the medical students; by making available to physicians the latest developments concerning the venereal diseases; and by the development of state diagnostic facilities for the use of practicing physicians.

Having accepted its share of responsibility for developing an appropriate equipment, the Public Health Service and its affiliated state organizations urge physicians at large to move for a general raising of the standard of treatment of venereal diseases. In the words of the resolutions:

This implies that a physician who is unfamiliar with or unprepared to employ modern methods in the management of these diseases should not accept such cases for treatment, but should refer them to some private or public physician who is properly equipped.

If the medical profession can treat the venereal disease patients adequately, the United States Public Health Service and the state boards of health pledge themselves not to invade the field of private practice in this phase of medical work.

The representatives of the public health services concede and define the value of the basic requirements of training for this work, and recognize as one of the essential requirements the provision of inspiration and incentive to individual development and reward for initiative.

The public health authorities further frankly concede that under existing conditions the Public Health Service cannot hope to offer a career with adequate returns to those who devote themselves exclusively to the work of venereal disease control; and recognize with equal justice the right of the highly trained man to seek in private practice the material return for special training and proficiency which public parsimony now denies him.

So sincere and genuine an effort at cooperation as this declaration represents, deserves the warmest response from the medical profession. It should be the privilege of the medical profession to bring its influence to bear to dignify public service in medicine. It is also the duty of the medical profession, and to its own interest, to cooperate in the development of educational and diagnostic facilities and to raise the standard of the treatment accorded the patient with a venereal disease.

The extinction of private practice in venereal disease is not a consummation to be wished, but it will be one to be deserved if the medical profession cannot measure up, by a process of internal organization and adjustment, to the standards of the most altruistic public agent in the field.

The United States Public Health Service and the state venereal disease bureaus, backed by one of the most powerful public sentiments now concentrated on any health problem, have expressed a desire for cooperation with the medical profession and indicated a way for its achievement.

Meetings, Conventions and Conferences

RURAL HOSPITAL VIEWPOINT EMPHASIZED AT BRITISH COLUMBIA MEETING

LAST year The British Columbia Hospital Association decided that it was advisable to take the annual convention into the interior of the Province to the smaller cities or towns, and thus carry much needed hospital propaganada into the rural parts of British Columbia where real hospital problems exist. Such an experiment was tried with some doubt and fear as to its success. However, with a splendid campaign previous to the time of the meeting to induce delegates to come, there was a good response, and the convention held at Kamloops July 6, 7 and 8, opened with the largest registration on record, and this continually increased till the last day. Almost every hospital in the Province was represented.

Kamloops is a pictureque city of 5,500 population, nestled on the banks of the Thompson River and surrounded by mountains. It is in the so-called dry belt, a mecca for tuberculosis patients owing to climatic advantages, there being situated about eleven miles distant the famous Tranquille Sanitorium, now under government management.

Kamloops Good Place for Convention

Kamloops has many advantages besides its unique location. It is a railway center for two transcontinental railroads: the Canadian National and the Canadian Pacific. It has many government offices for the interior, both Federal and Provincial. Above all this, however, its people are of the best, filled with real cordiality and community spirit, which manifested itself in a tangible way at every turn. No better place could have been selected, having splendid hotel accommodation and a high school which provided accommodation for all day sessions and for exhibits. The evening meetings were held in one of the churches. All sessions, and especially the evening sessions, were open to the public.

There were eight full working sessions extending over three days, with one evening given up to entertainment. Indeed, the hospitality of the Kamloops people, coupled with all the attractions such as golfing, tennis, fishing, boating, motoring, etc., might have ruined our convention had not the president, Dr. H. C. Wrinch, of Hazelton, and the secretary, Dr. M. T. MacEachern, of Vancouver, strictly insisted on minimizing the entertainment. It was strongly emphasized that this was a working convention and all abided thereby, but many waited over for two days after the meeting to participate in the pleasures they had resisted during the sessions.

The entertainment consisted of a motor trip to Tranquille Sanitorium, eleven miles distant, when the delegates were taken out by motor supplied by the Kamloops people. The delegates spent four hours of great pleasure and interest seeing this splendid institution. Over three hundred patients can be accommodated here. The institution is now under the control and management of the Provincial Government and with its fine location on Kamloops Lake, its splendid organization and equipment, it can hardly be surpassed in suitability for such a purpose. The delegates were received at the Sanitorium by the superintendent and staff, after which they were shown through the institution. At 6:30 p. m. all sat down to a fine dinner tendered by the management, at the conclusion of which all returned to the city for an important evening session. The next entertainment on the official program was the closing event on Friday evening, when a reception was held at the Royal Inland Hospital with a dance on the lawn. The Royal Inland Hospital is a most up-to-date institution of 102 beds, the largest of its kind for any town or city in Canada of the size of Kamloops. It stands upon a hill overlooking the city and the famous Thompson River. The board of directors, Miss M. P. Macmillan, superintendent, and the staff did all in their power to make the guests have a jolly time.

A new feature introduced this year was the get-together luncheon every day at the Leland Hotel. At these luncheons addresses were given and various measures adopted to increase acquaintanceship and good fellowship. The popularity of the luncheons can be judged from the fact that each day the number attending increased so that on the last day an additional dining room had to be provided. The luncheon feature of our program was so successful this year that it will probably be adopted as a practice at all the annual conventions.

The program throughout was excellent. This year there were very few papers but numerous round table conferences which proved better, as many who had never taken part in the past did so this year.

Throughout the convention the viewpoint of the smaller hospitals was always kept in mind, because it was fully realized that they are the ones who are constantly having real difficulties.

The first day was devoted to numerous nursing problems, especially as they affected the smaller rural hospitals. There was a large number of representatives from the nursing organizations of the Province who threw light on the different aspects as they were brought up.

The convention opened by the submitting of a report

by Miss E. I. Johns, R.N., director of nursing, Vancouver General Hospital, and assistant professor of nursing, University of British Columbia, which brought up several problems especially appropos to the smaller training schools. These problems had been elicited by a questionnaire during the year. The following are some of the matters considered:

(a) Affiliation of smaller training schools with the larger in the Province of British Columbia. This has been going on for a few years and the Vancouver General Hospital and the Provincial Royal Jubilee Hospital, Victoria, have been giving affiliation to smaller hospitals. On the part of the larger hospitals affiliation is quite satisfactory, but the smaller ones complain about losing the services of the nurse in the third year, when they go to the larger institution to take the special branches. Some of the smaller institutions wanted the time reduced to six months and others thought it should come out of the second year instead of the third. However, in spite of arguments advanced by the smaller training schools, the discussion ended by considering the present scheme as very satisfactory, and no change, therefore, will be made.

(b) Examination and registration of nurses in British Columbia from a hospital point of view. The workings of the B. C. Nurses' Registration Act was explained to the satisfaction of all. Some of the hospitals desired that the training schools should make provision for giving nurses training in executive work, so that they would be competent to administer smaller institutions when they went out. The matter was debated for some time and the nursing representation brought out clearly the fact that the curriculum now was so full that it would not be wise to add anything more to it.

Consider Institute for Superintendents

(c) An institute in British Columbia for superintendents of hospitals and training schools. This was presented in a report submitted by Miss Johns reviewing the experiences elsewhere. The report suggested an institute lasting from a few days to a week, or a regular course established in the University of British Columbia, similar to that which the teachers have each summer. The latter proposal was approved by the Association and steps will be taken to see if it can be established.

(d) Travelling instructors. It was found that throughout the Province in many places schools were greatly in need of more assistance in the instruction and teaching of nurses, and it was in many cases impossible to engage such a person on a full-time salary. It was learned that the B. C. Nurses' Graduate Association had the matter under consideration and are now looking into what subjects a traveling instructor could give so as to fill the need as well as possible.

Other important problems relative to nursing and nursing conditions arose. Living conditions for staff and pupil nurses in British Columbia hospitals came in for a good deal of discussion, and it was thoroughly impressed on all that in building hospitals due provision has not always been made for nursing accommodation, and that with the expansion of the institution proper nursing accommodation should be provided also. This point was thoroughly impressed on all present.

Miss Morrice Emphasizes Need of Tuberculous Care

The nursing care of tuberculous patients in British Columbia and the need for more experience on the part of our nurses in the care of these cases, was splendidly emphasized in a paper by Miss Jessie F. Morrice, R.N., superintendent of nurses, Provincial Sanitorium, Tranquille. Miss Morrice pointed out the need for special training in this work. The convention went on record as being in favor of establishing a training school in the Provincial Sanitorium whereby affiliation could be arranged for other hospitals in the Province.

Probably one of the most interesting features of the first day's program was a question box conducted by Miss K. Stott, superintendent of nurses, Royal Columbian Hospital, New Westminster. This question box contained ten practical subjects, and was disposed of at this session.

The evening meeting, which was conducted in the Kamloops Methodist Church, was largely attended by the citizens of Kamloops and district. Splendid addresses were given by His Worship, Mayor S. C. Burton of Kamloops, Mr. J T. Robinson, chairman of the board of directors, Royal Inland Hospital, Kamloops, and Dr. H. H. Murphy, secretary of the Medical Association of Kamloops. These were followed by an able address by Dr. H. C. Wrinch, president, reviewing the hospital situation in British Columbia from its medical, nursing, and financial aspects—making reference to hospital standardization and its promotion, to the nursing problems, especially as relating to the smaller hospitals in British Columbia, and to financial conditions, dwelling at length on the latter in explaining the proposed hospital tax by which the public hospitals of British Columbia could be financed. The main address of the evening, however, was "The Health Tax," by Dr. H. E. Young, Provincial Officer of Health, Victoria, in which was outlined the state's responsibility in connection with all phases of health, and a scheme proposed by Dr. Young which would start with prenatal care and carry on even to the grave. Dr. Young emphasized the fact that just as soon as the people of British Columbia demanded such a tax he was sure the government would be prepared to act.

Discuss Hospital Standardization

The second day had to deal entirely with medical service in our hospitals with special reference to hospital standardization. During the morning session hospital standardization was discussed from three aspects. The first paper was "The Hospital and the Medical Staff," presented by Dr. G. S. Purvis, general superintendent, Royal Columbian Hospital, New Westminster, in which it was shown clearly where the medical staff have a greater responsibility than possibly they realize, and should particularly be organized to keep careful supervision over all the work done within the institution. This paper was followed by one on "Medical Records in Our Hospitals," by Dr. L. G. Houle of Kamloops, who set forth the value of records and how they could be obtained and used. A most comprehensive paper on "Laboratory Service in Our Hospitals" was presented by Dr. G. F. Strong, assistant superintendent, Vancouver General Hospital. In this paper Dr. Strong set forth the need of laboratory service in all hospitals, and outlined the various tests and work that should be done in a hospital of one hundred beds and under. He concluded his remarks by presenting a list of equipment with cost, illustrating how this service could be carried on. If nobody was available in the institution to do this a nurse technician, who had taken the ten months course now offered in the Vancouver General Hospital, could acquire sufficient knowledge of medical records, x-ray and laboratory service, to do this work for the smaller hospitals. A hospital of fifty to one hundred beds could afford to pay such a technician for this work alone, but if the hospital had less than fifty beds she could possibly do supervision of nursing or assist in some other manner. The whole paper was exceedingly practical and a large number of the smaller hospitals immediately grasped the plan as outlined and expect to put it into effect.

Institution Should Investigate Infections

The afternoon brought up some interesting questions. Anesthesia was discussed by several of the medical men present, but very little new light was thrown on the subject. The question of post-anesthesia complications was discussed at length. A short discussion took place on infections in our hospitals following operation. Various views were submitted, but the point which was emphasized was that every institution should keep close record of each infection and investigate as to the cause. The tuberculosis problems of the general hospitals of British Columbia were emphasized many times throughout the convention, and it was clearly shown that while the government obligated every public hospital in the Province to set aside ten per cent of its beds for advanced tuberculosis cases, there were very few places where adequate accommodation and facilities were available for this work. To this end a resolution was set forth asking the Provincial Government to make provision in the hospitals to carry it on in order that they could comply with the regulations of the Act.

The public meeting in the evening was again largely attended by people from Kamloops and district. In the absence of Dr. H. R. Storrs of Vancouver, Dr. M. T. MacEachern gave a talk on hospital standardization and covered the usual points in the minimum standard requirement, making it very clear to all present. Hospital standardization was approved by all most enthusiastically and a special effort will no doubt be made to carry it out. The main address of the evening was given by the Reverend John Antle of Vancouver, who for seventeen years has been conducting the Columbia Coast Mission Hospital, and who has done a great deal of pioneer work. Through a wonderful series of slides he showed the medical and hospital service in the lumbering and industrial communities of British Columbia along the coast. In the series was shown the evolution of the medical and hospital service from the time it was carried on in a small boat until the present, when there is a series of hospitals all along the coast. Mr. Antle, with his wonderful series of slides showing the natural colors of the coast scenery and the workings of the lumbering industry, kept the audience spellbound for over an hour.

Hospital Financial Matters Occupy Last Day

The third and last day dealt entirely with hospital financial matters. A very interesting progress report was presented by Mr. E. S. Withers, managing secretary of the Royal Columbian Hospital, New Westminster, in which he dealt with a uniform system of hospital accounting and one which could be adapted to the needs of all hospitals in the Province. He pointed out that by such a method a better cost-accounting system and better comparative statistics could be secured. His report was also supported by a paper read by Mr. Henry Woods, secretary of the Vernon Jubilee Hospital, Vernon, in which he recommended the standardization of financial and other records in our hospitals. A splendid paper was presented by Mr. George R. Binger, secretary, Kelowna Hospital, Kelowna, on the present inadequate method of financing hospitals. This opened the great question of hospital financing, which took up all the afternoon of that day.

The main question before the Association the next morning was the Workmen's Compensation Act in its relation to our hospitals. This was presented by Mr. E. S. H. Winn, chairman of the Workmen's Compensation Board, Vancouver. There seemed to be good working harmony between the board and the hospitals excepting on one point, inasmuch as the board recently has been stopping payment for certain patients in hospitals several days and weeks before they were discharged, claiming that they should not be in the institution for that length of time. It was pointed out to the Workmen's Compensation Board that the discharge of the patient from the hospital was up to the doctor in attendance, and that the hospital should not be penalized if the doctor kept the patient in longer than the board considered necessary. The board argued that they were not administrative in function, but adjudicators and a court for the settlement of these claims. This point could not be settled and the matter stands as before.

Mr. Leders Reads Paper on Hospital Purchasing

The afternoon of the last day was devoted almost entirely to the discussion of hospital financial conditions, with the exception of a paper by Mr. R. B. Leders, purchasing agent of the Vancouver General Hospital, on "Purchasing for Hospitals," which was practically a continuation of his paper presented at the former convention. Discussion of the finances of hospitals showed clearly that the public institutions of British Columbia are in a distressing financial condition, and indeed considerable skepticism was expressed by many as to the real assistance the government would give the hospitals through the revenue from the Moderation Act now in force in the Province. Three schemes as to the future financing of hospitals were presented, all having their exponents. The first, the hospital tax, was discussed at length. This would provide hospital service. The second was health insurance, which would provide hospital and medical service to all persons employed, and earning up to a certain amount per year, or in other words, extension of the Workmen's Compensation Act to include the members of families. The third was the health tax, which would take care of all medical and preventive measures from the prenatal period for the entire duration of life. It was clearly seen that these were three different schemes, similar in principle though different in scope. After a long discussion it was resolved that a committee should be appointed to consider these three proposals and bring in a report. This committee, in addition to the president and secretary of the Association, consists of Mr. J. T. Robinson, chairman, Royal Inland Hospital Board; Mr. George McGregor, president, board of directors, Provincial Royal Jubilee Hospital, Victoria, and Mr. J. J. Banfield, member of board of directors, Vancouver General Hospital. This committee asked to confer with a committee from the Union of British Columbia Municipalities, Mr. E. S. H. Winn, chairman of the Workmen's Compensation Board, and Dr. H. E. Young, Provincial Officer of Health of the Province.

The convention concluded with a business session dealing with the affairs of the Association, and a vote of thanks to the Mayor of Kamloops, to the local committee, to the board of directors of the Royal Inland Hospital, to the citizens of Kamloops, to all who took part in the program, and many others.

This concluded the most successful convention ever held by The British Columbia Hospital Association.

A certain hospital board of managers thought the only way to manage a hospital and training school for nurses was to keep the superintendent of the hospital totally ignorant of the work and activities of the training school. It is easy to see that it is quite impossible for a superintendent to be held responsible for all departments unless he or she knows the daily condition of each department.

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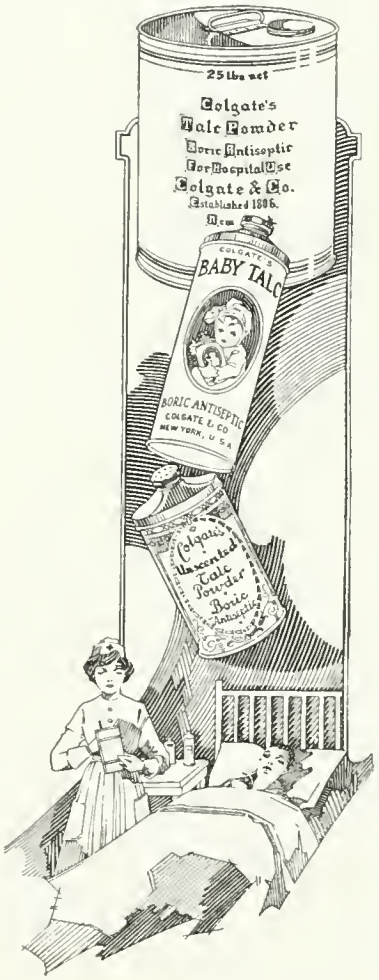

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ONTARIO ORGANIZES HOSPITAL ASSOCIATION

THE Ontario Hospital Association met at Niagara Falls, Ontario, on June 1. Dr. M. T. MacEachern, Vancouver General Hospital, discussed the problems of hospital organization, from the standpoint of the hospital and that of the Association. He also offered suggestions of a most practical character to the Association. The Association was very fortunate in securing the services of Dr. H. L. Brittain, director of the Canadian Research Institute of Canada, to speak of the relation of the hospital superintendent to the hospital board. Dr. Brittain has been for several years associated with the Toronto General Hospital as superintendent and secretary.

Following is a synopsis of Dr. Brittain's address:

THE RELATION OF THE HOSPITAL SUPERINTENDENT TO THE HOSPITAL BOARD

There are two ideas of this relationship.

(a) The board administers the hospital, and the superintendent is a rubber stamp.

(b) The superintendent administers the hospital, and the board is a rubber stamp.

The meaning of this is clear to all. There are few who have not seen evidence of both of these ideas. Hospitals where trustees wrongly take upon themselves administrative authority and who attempt to give orders to any and all of the employees of the hospital regarding the operation of their respective departments. This practice cannot but have a bad effect upon the discipline, and a detrimental effect upon the superintendent. Unless the superintendent is a very strong man he will gradually lose initiative and power of decision, and some to depend upon the board—in short, become a rubber stamp for the board.

On the other hand there are those boards of trustees which are literally domineered over by the superintendent. Boards which are unfamiliar with the operation of their hospital and who endorse, as a matter of routine, everything the superintendent does, simply a rubber stamp for the superintendent's use. Needless to say, both of these ideas are wrong. There are three main activities in the management of a hospital as of any other institution: The formulation of policies, the determination of policies, the carrying out of policies.

The carrying out of policies is the sole function of the superintendent.

The formation of policies should, if the superintendent is the right man, come usually from the superintendent who is most qualified by an intimate knowledge of all conditions to take the initiative. However, any member of the board has, at the same time, the right and the duty to suggest policies, but in such cases no action should be taken without referring the matter to the superintendent for his careful consideration and report upon the matter.

Policies, whether originating with the superintendent or the board, should be discussed by the superintendent with the board, determined by the board, and executed by the superintendent. If the superintendent will not or does not carry out the policies as determined by the board, let the board get a new superintendent, but under no consideration should the board take any part in the internal management of the hospital.

FINANCIAL CONTROL:

The board is responsible to the public for the proper financial control of the institution. The control is effective in three ways: (a) An annual budget; (b) Monthly report; and (c) An independent audit.

During the period of the war a budget was of little or no value because of very rapid fluctuations of market commodities and labour. In normal times, however, the superintendent should be asked to prepare a budget setting forth the requirements of the hospital with as much detail as possible.

The board should insist upon monthly reports accompanied by financial statements showing the cost of operation in detail.

An audit of the books of the hospital by an accountant appointed by the board.

ADMINISTRATIVE CONTROL:

The board is responsible to the public for proper administrative control. This may best be obtained by monthly reports from the superintendent covering the work of the various departments. This report should be read at the regular monthly meeting of the board and should be fully discussed.

Monthly reports to the superintendent by the department heads and presented by him to the board.

Insistence on staff meetings, not only of the medical and surgical staffs, but of the administrative staff.

DISCIPLINE:

Discipline is a matter for the superintendent directly. Any attempt to obtain administrative control by board members through private inquiries is subversive of discipline. All orders should be given through the superintendent. Casual orders by board members to employees are not only apt to lead to mistakes but are fatal to discipline and staff cooperation. The fundamental duty of a board is to appoint a superintendent, insist on complete information from him, visit the hospital and inspect his work frequently, back him up to the limit when he is right, and discharge him when he habitually goes wrong.

BOARD MEETINGS:

Too much importance cannot be attached to the monthly meetings of the hospital board. The trustees should attend these meetings as they would a directors' meeting of their own business. Strict attention should be given to the reports read by the superintendent at these meetings. In this way the board will gain a better appreciation of the work of the hospital from month to month. The attendance of hospital trustees and their strict attention to the business of the meetings makes for better trustees and a better superintendent. Better trustees because they become familiar with the operation of their institution, and a better superintendent because he realizes that the trustees regard this work seriously and are holding him accountable for efficient operation of the hospital from month to month.

HOPE TO COMPLETE GARDEN CITY SANATORIUM IN FRANCE

Dr. André Baillon, laureate of the faculty of medicine, Paris, and president of the Franco-American Committee to Fight Tuberculosis, is now in America, completing the organization of the American membership of the committee, and forming sub-committees in cities outside New York, with the idea of completing the Garden City Sanatorium, in Provence, France. The sanatorium will care for French soldiers who contracted tuberculosis as a result of the war, and for children of devastated regions in northern France, who suffered from exposure during the German occupation. A site for the sanatorium has been selected in the Esterel Mountains overlooking the Mediterranean. One hundred children, who are now being cared for by the American committee for the relief of the devastated regions of France will be transferred to the sanatorium as soon as it is finished.

CINCINNATI, OHIO TO HAVE HEALTH EXPOSITION

The Cincinnati Health Exposition which will be conducted in that city, during the week beginning October 15, will endeavor to show the public the ways in which human life may be preserved, and in which shattered health may be regained. There are seventy-five local, eleven state, and five national organizations actively interested in the undertaking. Among these are the Academy of Medicine, Red Cross, Board of Education, all hospitals, the courts, mercantile associations, churches, welfare societies, the University of Cincinnati, and Boy and Girl Scouts.

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Book Reviews and Current Hospital Literature

THE AMERICAN HOSPITAL OF THE TWENTIETH CENTURY

By Edward F. Stevens, Architect, Member of American Institute of Architects, Member of Royal Architectural Institute of Canada, Member of American Hospital Association; 380 pages.*

SURPRISINGLY few books have been written on American hospitals. In almost every other form of activity the worker has no sooner laid down his tool, the artist his brush, or the actor stepped from the stage, than he hastens to tell in printed form how he did it. It seems that many of them, not really knowing how they did it, try to convince themselves that they know by telling someone else. Probably when Noah completed the Ark he rushed to get a slab of stone, and a hatchet and chisel to hack out the story. Perhaps planners and builders of hospitals have been too busy to drop their tools and start writing about it, or perhaps they knew their business so well that they did not need to assure themselves of the fact. Whatever the cause, the unfortunate effect has been a great dearth of material on this important subject. When the author of "The American Hospital of the Twentieth Century," Mr. Edward F. Stevens, Boston, Mass., realized this situation he felt that the most crying need in the hospital field was for someone to collect material on what has already been done, so that hospital builders of the future may profit more easily by the lessons of the past.

Mr. Stevens has drawn on the plans of European hospitals partly because there is a great deal of literature on that subject, and partly because American institutions are greatly indebted to the hospitals of Europe. While buildings adapted to one climate could not be appropriately duplicated in another, yet European hospitals have greatly influenced those of our country. The general relation of one department to another, the housing and treatment of patients, the orientation and environment, and the proportion of sunlight and shadow, are things in which they have played an influential part.

Mr. Stevens has, in this book, gathered together a remarkably interesting and instructive collection of hospital plans both from this country and from Europe, and as a running commentary beside them he gives valuable information on many of the perplexing problems of hospital planning. As he states in the foreword, "It is not the writer's intention to criticize the plans of the various institutions here shown but to present them as various solutions of the great problems of housing and caring for the sick, and to point out a few of the findings of his own experience in the planning of more than fourscore hospitals and institutions. The field is so broad it is impossible more than to touch upon the various points."

*The Architectural Record Company, New York, 1921.

In the first chapter, entitled "In General," Mr. Stevens gives a brief historical outline of the growth of hospitals and the various influences, for example, medical, nursing, social and other types of service, which have played their part in shaping the ever-changing and gradually improving hospital ideal. The hospital site is important, for the institution must have room in which to expand. A southern exposure is desirable, in the country it is well to have the site sheltered on the north. By cleverly arranged diagrams, the author shows the various situations with regard to orientation of buildings. In considering all questions the fundamental problem is "to give the patient the best chance for recovery." After a general statement of the question under consideration, the author in this as in other chapters of the book, makes a brief comment on each of the hospitals of which plans are shown, pointing out a few of the especially interesting or desirable features.

The administration department, the author feels, should in most cases be the central unit through which all patients except stretcher cases must pass. Here also would be the offices of the superintendent, admitting officer, bookkeeper, and superintendent of nurses; also the staff and board room and the medical library. Many interesting illustrations of hospital entrances are given.

The ward unit, which is the keynote of the hospital, since it is where the patient eats, sleeps, and lives, should be built only after exceedingly careful study as to how these things can be best accommodated. "Best" will mean here with the greatest comfort for the patient. This unit will necessarily vary with the kind of disease which is to be treated in it; but there are certain essentials which apply to all wards and which are clearly outlined, and illustrated by a large number of plans and pictures.

The surgical department in American hospitals has greater variety than the ward unit. It is probably impossible to say, therefore, what is the ideal arrangement for this important part of the institution. European hospitals do not help us in this respect because, while most of the foreign hospitals have only one operating room, since practically all the operations are done by one surgeon, we find our comparatively small hospitals containing five or six operating rooms. The methods of surgery are so constantly changing that the architect must work hard and fast in this as in all branches of the hospital to keep up with or better, ahead of the times.

In a like comprehensive way with text and illustrations, Mr. Stevens has treated fifteen other subjects, among them: the maternity department, the children's department, the department for communicable diseases, the psychopactic department, the tuberculosis department, the laboratories, the nurses, residences, the kitchen, laundry, etc.

The first edition of this book has been thoroughly revised, and much new material added, so that this edition is a book no one interested in hospitals can afford to miss.

Adv. Page 14

Appetite and Digestibility

No appetite means a slow digestion. What does not "make the mouth water" will not make the gastric juices flow easily. Food must be tempting.

Biscuits, muffins, cake, etc., made with

ROYAL Baking Powder

are both delicious and digestible because of their lightness, due to the strong leavening action of the powder.

They are, moreover, healthful because Royal Baking Powder is made from cream of tartar and adds to food the same wholesome qualities that exist in ripe grapes, from which cream of tartar is derived.

Food made with Royal Baking Powder possesses excellent keeping qualities and fine flavor, stimulating to the appetite and digestion as well.

Royal Baking Powder contains no alum

Consult the 1920 Year Book for Catalog information.

Hints to Hospital Superintendents

SAVING SOAP

As you know, fresh soap melts away as chaff before the wind. It is a good plan, therefore, to buy cake soap in quantity and lay it away on your top shelves to dry out thoroughly before it is used. Oval cakes of soap waste less than those having square corners. If your bill for white soap seems more than necessary, watch the requisitions to see if your supervisors know if cakes are left to melt in washtubs or are thrown out with wash water, or if partly used cakes are kept for future use.

If your bill for green soap seems excessive, see how much is leaking out of the soap containers, how much is used for shampoos, how much is going into the scrub pails, and if accurate measurement is used in making solutions.

INVENTORIES SHOULD BE KEPT

Have you an efficient inventory for the supplies of your hospital? A card index system of perpetual inventory should be kept, filed alphabetically, and containing only the standard and not perishable things. Such a card system should contain the name of the article at the top and headings across as follows: "Date of Purchase," "From Whom Purchased," "Quantity," "Withdrawals," "Balance on Hand," and space for remarks.

Special inventories are only useful if they are kept up to date, and for this reason their usefulness is often doubted. If your supplies of all kinds are carefully requisitioned, and check kept of breakage and replacement, and if the storerooms are in charge of capable and conscientious people, a perpetual inventory, which takes necessarily a great deal of time and labor, might be dispensed with.

ARE YOUR PUPIL NURSES DOING "SPECIAL DUTY"?

Are you one of those unfortunate superintendents who has just taken charge of a private hospital which has managed to enroll a large class of pupil nurses, and is deriving an unwarranted income by having them do special duty for wealthy patients? If so, take heart from the experience of one of the graduates of an institution of this character who served the institution as its superintendent for a period of five years, in which time, by almost superhuman effort, the methods of the training school have been largely altered for the better, to the extent that at the present writing this school is recognized by the state board of examiners, and its graduates are eligible for state registration. Discouragements and objections from the hospital board there were, to be sure, but pluck, perseverance, hard work, and loyalty to her own training school won the battle.

COLLECTING LOST ARTICLES

Have you ever thought of establishing a lost and found station in your hospital? Things are continually getting lost in any institution, and if there is a central point at which they may be collected, much time and trouble is saved. Think of the wandering screws, bolts, wheels, casters, which could then find their proper resting place! Instead of picking something up from the floor and placing it upon a window sill, perhaps, trusting to luck that the owner may find it, the finder, whether janitor or member of the staff, would know where to deposit it. Have you ever wondered who collects the lost handkerchiefs which one sees draped over a post, tied to a fence, or pinned to a tree? Someone may have established a lucrative business in this line. You may find the business of collecting lost articles in a lost and found station in your hospital as lucrative. It will pay to try.

FOOD MAY PUT YOUR HOSPITAL "ON THE MAP"

Do you lament the fact that your hospital is not "on the map"?

Perhaps the reason is the one that was discovered by the superintendent of a small hospital, administered by an excellent board of trustees, who made the all too unremarkable discovery that no hospital in the city served palatable food either to its patients or to its employees.

Acting on this cue, she secured the best cook she could find, and a thoroughly trained dietitian, and, with her good judgment in buying supplies, easily won, within the short period of three months, the reputation of serving the best trays in the hospitals of that city. As a result, the hospital could not accommodate all the patients which the medical and surgical men of the town, who realized the therapeutic value of good food, wished to send there.

LET OTHERS BE THE PATH BREAKERS

It would be just as well if hospital people who have not a great deal of money to spend would let others be the path breakers. It is expensive to try out new devices, materials, or machines in your institution. It is very well for some to try them out, but they should be the individuals and institutions which have money for what is frankly experimentation. New ideas are being marketed every day in the hospital field, and about 90 per cent of them, perhaps, are failures because the inventor did not understand the hospital side of the thing he wished to invent. He saw only the manufacturing side. Therefore, unless you wish to take a risk, when you are buying something new, find out where it has been used, and what kind of service it gave from the point of view, not of the manufacturer, but of the hospital administrator.

Adv. Page 16

AMERICAN HOSPITAL ASSOCIATION

Annual Conference and Hospital Exposition

WEST BADEN, INDIANA — SEPTEMBER 12-16, 1921

Program and Exposition Guide

SUPPLEMENT
The MODERN HOSPITAL
September, 1921

In Booth No. 1

AT the A. H. A. Convention, September 12-16, we will occupy Booth No. 1, where we shall be equipped to give our friends the latest facts about the markets, grades, and prices in our complete line of institutional food products.

Markets, particularly on canned fruits and vegetables, are unusual this year. As America's largest distributors of No. 10 canned goods, our contact with crop prospects and primary markets keeps us closely in touch with conditions.

Hospital officials attending the Convention are particularly invited to inspect our sample lines, which will be arranged to assist those who buy, in supplying the institutional table with quality foods economically.

John Sexton & Co.

Importers, Wholesale Grocers and Manufacturers

CHICAGO

THE CONFERENCE AND THE EXPOSITION

THE Twenty-third Annual Conference of the American Hospital Association will be held at West Baden, September 12-16, 1921.

The meetings are wide open to any and all of the hospital field. The admission pass is not membership in the Association; it is interest in the service rendered by hospitals to the public, and that alone.

The spirit of service dictated the program—the spirit of helpfulness to those who are directing the service given by the institutions to the patients. It was designed to solve as many as possible of the numerous problems that here and there are troubling those responsible for results and upon their own resources. It was designed to bring to the ones in trouble the solutions worked out by others. It is pointed and practical.

As a part of the practical program there will be an exposition of equipment and supplies in which the same spirit of service will prevail. The list of men who really know about some particular equipment or supply used in a hospital and who will attend the exposition to give you the benefit of their technical knowledge without obligation on your part is steadily growing. The full list of these men and the problems covered by them will be published at West Baden in the official daily bulletin.

While it is undoubtedly true that correct diagnoses are the most important part of the hospital service, the non-professional part, which may be called the "hotel service" part, is quite important. It means comfort and happiness to the patients, therefore you should not neglect it. It also means the greater part of your income.

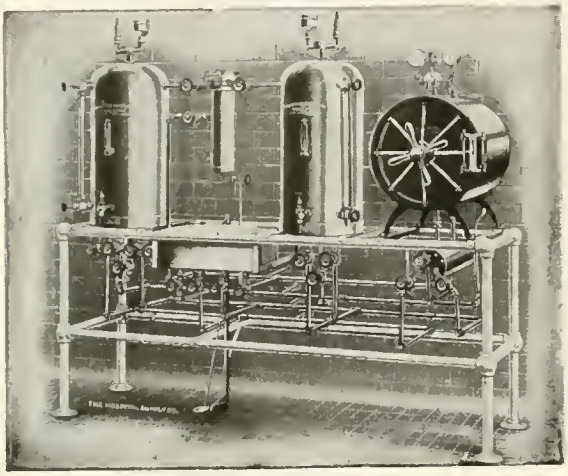
Search the exposition for new ways to make your "hotel service" to the patient more satisfactory or to carry on your present service at less cost. Come with your defects and problems in this service in mind. You may find just the right solution to them, and you will at least learn what others are using. Come with your inventory of stocks in mind or on paper; you can learn here the general market on the various items and you can here get quotations on goods you have seen and thereby know their suitability.

Isolation and progress cannot exist together. Your policy must be one or the other—in practice as well as in theory. This is the year's opportunity for concentrated contact with the rest of the hospital world. You must think seriously before you allow yourself to miss it, think of the effect on the practice of your policy and upon your work.

Will your decision be for isolation or for progress?

THE HOSPITAL SUPPLY COMPANY NEW YORK

Some of the things you should not fail to see at the convention—

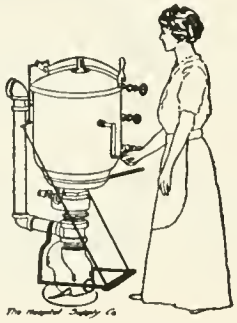


The Most Modern in Sterilizers
A Battery of "CLIMAX" Sterilizers

—a few examples of what will constitute the largest and most complete display of modern hospital equipment and supplies ever gathered for such an occasion for exhibition to the hospital public

THE NEW "CLIMAX"
BEDPAN EMPTIER, WASHER AND STERILIZER
Model No. 5 Improved

You will find it a revelation.



LOOK FOR BOOTHS 101 and 115

We will be well represented with a number of capable persons who will gladly confer with you on your hospital problems and furnish you with such advice as can be expected from men with more than 20 years experience in hospital work.

"COSMO" ASEPTIC STEEL FURNITURE
WILL BE WELL REPRESENTED

The New "ERDMAN" Pedestal Operating Table, the latest in hospital equipment design, will be one of the features of the display.

YB
Page 526

A large assortment of Glassware, Enamelware, Rubber Goods, Surgical Instruments, and General Sundries, comprising our

"WATTERS LINE"

will be well worth looking over

THE HOSPITAL SUPPLY CO.
THE WATTERS LABORATORIES
155-7-9 East 23rd Street New York, N. Y.

and the WATTERS LABORATORIES CONSOLIDATED

PROGRAM

OF THE

TWENTY-THIRD ANNUAL CONFERENCE

OF THE

AMERICAN HOSPITAL ASSOCIATION

MONDAY, SEPTEMBER 12

2 P. M. Atrium of the Hotel.

Registration.
Formal opening of the exposition.

8 P. M. Atrium of the Hotel.

Reception, music and dancing.

TUESDAY, SEPTEMBER 13

10 A. M. Convention Hall.

Open session, President Baldwin presiding.

Address of Welcome.
Governor W. T. McCray of Indiana.
Address of the President.
L. B. Baldwin, M.D., Superintendent of University of Minneapolis Hospital, Minneapolis, Minn.
Report of the Trustees.
Report of the Executive Secretary.
Report of the Treasurer.
Report of the Membership Committee.
Report of the Service Bureau on Dispensaries and Community Relations.
Report of the Service Bureau on Hospital Social Work.
Routine Opening Business; Appointment of Committees.
"Salaries Hospital Superintendents Are Now Receiving."
Joseph J. Weber, Managing Editor, The Modern Hospital, Chicago, Ill.

2 P. M. Convention Hall.

General Session, President Baldwin presiding.

"The Development of Good Professional Work in the Hospital."
Charles S. Woods, M.D., Superintendent, Methodist Episcopal Hospital, Indianapolis, Ind.
Discussion.

3 P. M. Convention Hall.

General Round Table on What Constitutes Good Service to the Patient.
Conducted by M. T. MacEachern, M.D., Superintendent, Vancouver General Hospital, Vancouver, B. C.

8 P. M. Convention Hall.

General Session, President Baldwin presiding.

Address.
Haven Emerson, M.D., Medical Advisor and Assistant Director, Bureau of War Risk Insurance, Washington, D. C.

(Continued on Page 7)

Dougherty's

will exhibit in spaces 16, 17 and 18, some of the newest productions of

The "FAULTLESS" Line

OF

Hospital Equipment

including

1—The 1921 St. Lukes Model, All Steel Private room equipment, consisting of bed, dresser, bedside table, adjustable table, costumer, wardrobe, nurses' cot, in antique ivory rubbed finish, striped in Holland Blue.

2—The Faultless Operating table (patent pending) simple in design and giving all required positions; with construction of such character that changes in position are made in less time than possible with any other table.

3—The No. 2312 Dougherty Obstetrical bed, with latest improvements, a divided bed which has no equal.

4—The No. 6276 Adjustable bedside table, which has no "Spring" and does not sag.

5—Cabinets, Chairs, and supplies as space will permit.

Messrs. Mitchell, Leinbaugh, Leavell, Swenson, and Dougherty will be glad to greet you and render any service possible in the selection of your Hospital needs.

H. D. Dougherty & Company, Inc.

17th & Indiana Ave.
PHILADELPHIA, PA.

Dougherty's "Faultless" One-Piece Aseptic Steel Hospital Furniture

PROGRAM—Continued from Page 5.

WEDNESDAY, SEPTEMBER 14

10 A. M. Convention Hall.

Section on Dispensary.

Chairman, John E. Ransom, Superintendent, Michael Reese Dispensary, Chicago, Ill.
Secretary, Clarence E. Ford, Superintendent, Division of Medical Charities, State Board of Charities, Albany, N. Y.

Dispensary Problems of the Large City.
Michael M. Davis, Jr., Executive Secretary, Committee on Dispensary Development, New York City.

Dispensary Problems of the Small City.
S. G. Davidson, M.D., Superintendent, Rockford Hospital, Rockford, Ill.

Dispensary Problems of the Rural Community.
(Speaker will be announced in the American Hospital Association's Daily Bulletin.)

10 A. M. Assembly Hall.

Section on Hospital Construction

Chairman, George O'Hanlon, M.D., Superintendent, Bellevue Hospital, New York City; Secretary, Oliver H. Bartine, New York City.

Round Table on Hospital Construction Problems.
Conducted by the Chairman of the Section.

2 P. M. Convention Hall.

General Round Table on Departmental Problems.
Conducted by Asa S. Bacon, Superintendent, Presbyterian Hospital, Chicago, Ill.

2 P. M. Assembly Hall.

Section on Administration.

Chairman, A. C. Bachmeyer, M.D., Superintendent, Cincinnati General Hospital, Cincinnati, Ohio.
Secretary, C. G. Parnell, M.D., Superintendent, University Hospital, Ann Arbor, Mich.

"How Hospital Records can Contribute to Health Protection."
Haven Emerson, M.D., Medical Adviser and Assistant Director, Bureau of War Risk Insurance, Washington, D. C.

Report of the Special Committee Making the Study of the Recording of the Hospital's Work.
A. C. Bachmeyer, M.D., Chairman.

8 P. M. Assembly Hall.

Section on Social Service.

Chairman, Ruth V. Emerson, Secretary, American Association of Hospital Social Service Workers, Washington, D. C.

Secretary, Bess Lynde Russell, Director of Social Service, Michael Reese Hospital and Dispensary, Chicago, Ill.

"Hospital Social Service as it Relates to the Administration of Dispensaries."
Janet Thornton, Member of Staff, Committee on Dispensary Development, New York City.

Discussion opened by John E. Ransom.

"The Hospital Social Service Department as it is Related to the Medical Care of Patients."
Bess Lynde Russell, Director of Social Service, Michael Reese Hospital and Dispensary, Chicago, Ill.

Discussion.

8 P. M. Convention Hall.

Round Table on Administrative Problems.
Conducted by A. C. Bachmeyer, M.D.

9 P. M. Convention Hall.

Round Table on Dispensary Problems.
Conducted by John E. Ransom, Chairman of Dispensary Section.

8 P. M. Moving Picture Hall.

Special Meeting for Hospital Trustees.

(Continued on Page 9)

Curity—

Absorbent Gauze,
Allied Products,
and Cellucotton

BOOTH 19
American Hospital
Association Convention
September 12-16th

Lewis Manufacturing Co., Walpole, Mass.

PROGRAM—Continued from Page 7

THURSDAY, SEPTEMBER 15

10 A. M. Convention Hall.

Section on Nursing.

Chairman, Mary M. Riddle, R.N., Superintendent, Newton General Hospital, Newton Lower Falls, Mass.
Secretary, Jessie C. Catton, Superintendent, Lawrence General Hospital, Lawrence, Mass.

"The Eight-Hour Day, Its Advantages and Disadvantages; Arrangements Required for its Establishment."

"The Shortage in Prospective Nurses, Causes and Remedies."

"The Necessity for an Adequate and Reliable Curriculum in the Training School."

"The Advisability of an Attractive Prospectus; How to Construct It."

"A Plea for Fewer and Less Comprehensive Questionnaires Between Training Schools or Allied Organizations."

"A Plea for Simpler Records in Training Schools; How to Secure Them."

"Some Present Day Problems and Dangers Besetting Training Schools."

The above subjects will be presented in brief five minute papers. Ample time will be given for discussion.

10 A. M. Assembly Hall.

Open Session of American Conference on Hospital Service.

President, Frank Billings, M.D., Professor of Medicine, University of Chicago, Chicago, Ill.

Report and Remarks.
Frank Billings, M.D., President.

Report of the Hospital Library and Service Bureau
Donelda R. Hamlin, Director, Chicago, Ill.

Report of the Treasurer.
Harry E. Mock, M.D., Treasurer, Chicago, Ill.

Report of the Trustees.
A. R. Warner, M.D., Acting Secretary, Chicago, Ill.

Report of the Special Committee to Work Out the Procedure in the Determination of Policies as to Hospital Service.

Election of Officers.

2 P. M. Convention Hall.

Joint General Session of the American Conference on Hospital Service and the American Hospital Association.

Frank Billings, M.D., President of the Conference, presiding.

Address.
John G. Bowman, Ph.D., Chancellor, University of Pittsburgh, Pittsburgh, Pa.

Discussion.

"A Method of Increasing Medical Efficiency Within the Hospital."
Franklin R. Nuzum, M.D., Medical Director, Santa Barbara Cottage Hospital, Santa Barbara, Cal.

Discussion.

8 P. M. Convention Hall.

General Session, President Baldwin presiding.

Presenting Reports of Special Activities of the Association.

Report of the Special Committee Studying Flooring Materials for Hospitals.
Frank E. Chapman, Chairman.

Report of the Special Committee on the Subject of the Relation Between Hospitals and the State and City.
John E. Ransom, Chairman.

Report of the Special Committee Studying Hospital Forms and Records.
A. C. Bachmeyer, M.D., Chairman.

Report of the Special Committee for the Study of State Subsidy for Hospitals.
Howell Wright, Chairman.

Report of Progress from the Special Committee Studying the Education of the Hospital Social Worker.
Michael M. Davis, Jr., Ph.D., Chairman.

(Continued on Page 11)

H.W. BAKER LINEN CO.

will have their usual attractive and full line of Hospital Linen requirements on display at their Booth 117 at the American Hospital Association's Convention, to be held at West Baden Springs, Ind., September 12th to 16th, 1921.

Mr. L. C. Walker, Sales Manager, who has attended the previous Hospital Conventions, will be in charge.

All those in attendance are cordially invited to visit Booth 117 and take advantage of this unusual display of Hospital Linens.

SHEETS AND PILLOW CASES
BED SPREADS
COMFORTABLES
BLANKETS
THROW BLANKETS (FANCY)
MATTRESS PROTECTORS
STAND COVERS
BUREAU SCARFS
SQUARES
COATS AND APRONS FOR ATTENDANTS
BATH MATS
TABLE FELT

TRAY CLOTHS
MUSLINS
NAPKINS (LINEN)
NAPKINS (COTTON)
TABLE CLOTHS (LINEN)
TABLE CLOTHS (COTTON)
TABLE TOPS (LINEN)
TABLE TOPS (COTTON)
TABLE DAMASK (LINEN)
TABLE DAMASK (COTTON)
DOILIES (COTTON AND LINEN)
HUCK TOWELS
FACE TOWELS

HAND TOWELS
BATH TOWELS
ROLLER TOWELS
KITCHEN TOWELS
COOK'S TOWELS
SIDE TOWELS
GLASS TOWELS
DISH TOWELS
PANTRY TOWELS
DOCTORS' OPERATING GOWNS
NURSES' OPERATING GOWNS
PATIENTS' GOWNS
CHEESE CLOTH (BLEACHED)
CHEESE CLOTH (UNBLEACHED)

H.W. BAKER LINEN CO.

BOSTON
PHILADELPHIA

41 Worth St.,
NEW YORK, N. Y.

LOS ANGELES
SAN FRANCISCO

PROGRAM—Continued from Page 9

FRIDAY, SEPTEMBER 16

10 A. M. Convention Hall.

General Session Conducted by Section on Dietetics.

Chairman, Lulu G. Graves, Mount Sinai Hospital, New York City.
Secretary, Marion Peterson, Chief Dietitian, Swedish Hospital, Minneapolis, Minn.

"Food Preservation."
John Phillips Street, Indianapolis, Ind.

"Practical Suggestions for Hospital Dietary Departments."
Rena Eckman, Chief Dietitian, University Hospital, Ann Arbor, Mich.

11 A. M. Convention Hall.

General Session, President Baldwin presiding.

"Cooperative Purchasing by Hospitals."
Guy J. Clark, Purchasing Agent, Cleveland Hospital Council, Cleveland, Ohio.

General Round Table on Purchasing Problems.
Conducted by Mr. Clark.

(Continued on Page 13)

Members of the American Hospital Association and other visitors to the West Baden meeting are cordially invited to inspect the exhibit there of

Stedman Naturized Flooring

A very comprehensive and impressive display of the different types and color effects in this unique and beautiful flooring material, including sample floors designed particularly for hospital use, has been provided for this occasion.

Other interesting features at the Stedman booth are examples of the new mottled or veined types of flooring here shown for the first time, together with various samples of Stedman Naturized Flooring which have been subjected to those soiling and staining agents more or less common in hospital routine.

Stedman Naturized Flooring is a product formulated from rubber reinforced with cotton fibre under vulcanizing heat and great hydraulic pressure, resulting in a material so integrally tenacious as to withstand the shock of severest tractive abrasion. Adamantean, yet resilient.

Silent, sanitary, non-slippery, comfortable, Stedman Naturized Flooring constitutes a distinct improvement over any other manufactured floor for hospital use. Demonstrations of its advantages will be conducted throughout the week of the West Baden meeting.

STEDMAN PRODUCTS COMPANY

South Braintree, Massachusetts

New York Offices: 101 Park Avenue

We Cordially Invite You

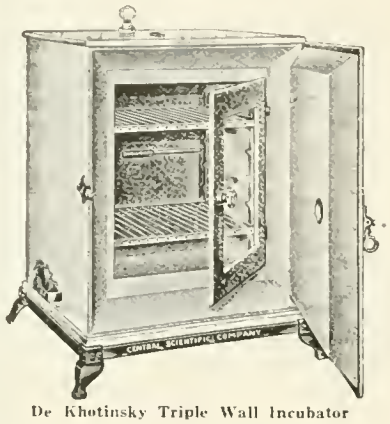
to visit

Booths Nos. 59 and 60

at the

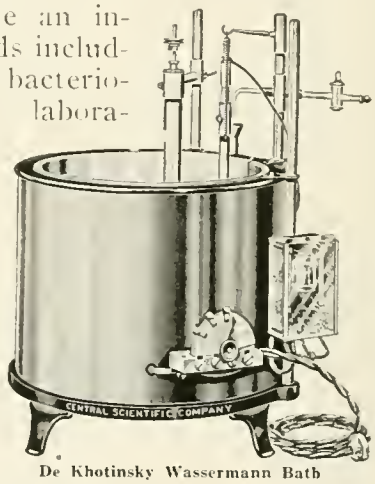
AMERICAN HOSPITAL ASSOCIATION EXPOSITION

At West Baden Springs Hotel, West Baden, Ind.
September 12-16th, 1921.



De Khotinsky Triple Wall Incubator

We shall have on exhibition at our booths a complete set of apparatus and chemicals for pathological and bacteriological laboratories. We shall have in charge of our exhibit a man who is thoroughly familiar with the requirements of such laboratories, having made an intensive study of their needs including visits to hundreds of bacteriological and pathological laboratories.

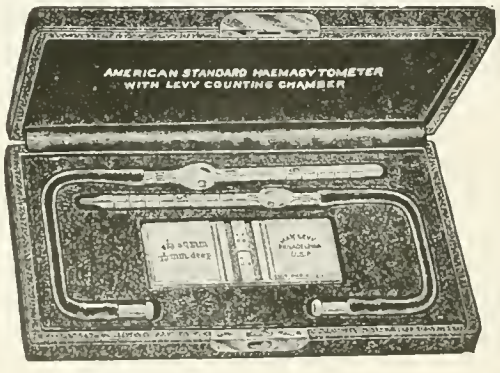


De Khotinsky Wassermann Bath

Suggestive Lists

We have recently compiled a number of lists of laboratory equipment to meet the needs of hospitals doing various types of work, and our representative will be very pleased to talk over your requirements and make recommendations to suit local conditions. We hope you will come to the meeting prepared to discuss your present or future plans with us and allow us to lend you such assistance as our considerable experience in this line places us in a position to render.

A Service Organization



Blood Counting Apparatus

We have always believed that a scientific supply house has a greater function to perform than that of merely merchandising. We believe that it occupies the function of a service organization, in that it possesses not only a stock of apparatus but also a vast fund of information regarding apparatus and methods, which has been accumulated through years of experience in handling such material. This information we believe should be placed at the disposal of laboratory workers since it will relieve them of the burden of searching through reams of literature and the impossible task of sifting the findings in the light of the experience of hundreds of workers. We regard it a privilege to render this kind of service and are more than pleased to have you come freely to us for it.

CENTRAL SCIENTIFIC CO.

460 East Ohio Street

CHICAGO U. S. A.

PROGRAM—Continued from Page 11

FRIDAY, SEPTEMBER 16.—Continued

10 A. M. (Place to be announced later).

Executive Session, American Conference on Hospital Service.

2 P. M. Convention Hall.

General Session, President Baldwin presiding.

"Where to go for Money."
R. M. Bradley, Trustee, Thompson Trust, Boston, Mass.

Discussion.

Closing Business.

Reports of Committees.
- Report of Committee on Constitution and By-Laws.
- Report of Committee on Resolutions.
- Report of Committee on Time and Place.
- Report of Auditing Committee.
- Report of Nominating Committee.
- Reports of Special Committees.

Election of Officers.

The New President Takes the Chair.

Special Business.

Adjournment.

THE PIONEER INSTITUTION SUPPLY HOUSE
EST. 1891
RHOADS & COMPANY
PHILADELPHIA, PA.

AT BOOTH No. 56—

—a complete and interesting exhibit of

THE BEST IN HOSPITAL TEXTILES

—such as linens, blankets, bedding, garments,
In fact, everything made of cotton, linen or wool.

Do not leave the convention without satisfying yourself as to our capacity to give prompt, exact, intelligent and economical service

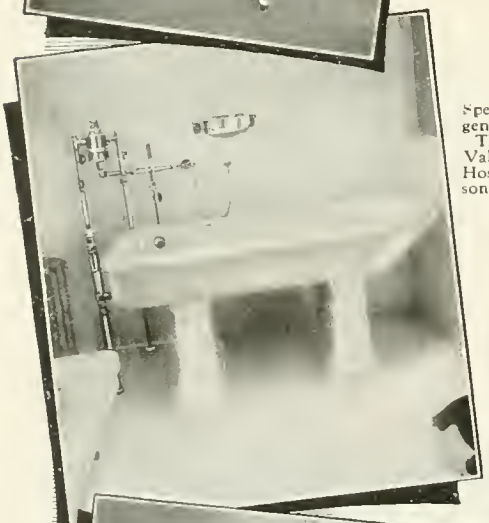
RHOADS & COMPANY

1023 Filbert St.
Philadelphia

Elliott Hospital, University of Minnesota.

Baby Bath, Special Baby Rinsing Bath; Lavatory. City Hospital, Jersey City, N. J.

Public Toilet Room Lavatories. Ford Hospital, Detroit, Mich.



Special Emergency Bath, with Thermostatic Valve, Barnert Hospital, Patterson, N. J.

Clinic Slop Sink, air control valve for flushing; Surgeons' Sink, Barnert Hospital, Patterson, N. J.

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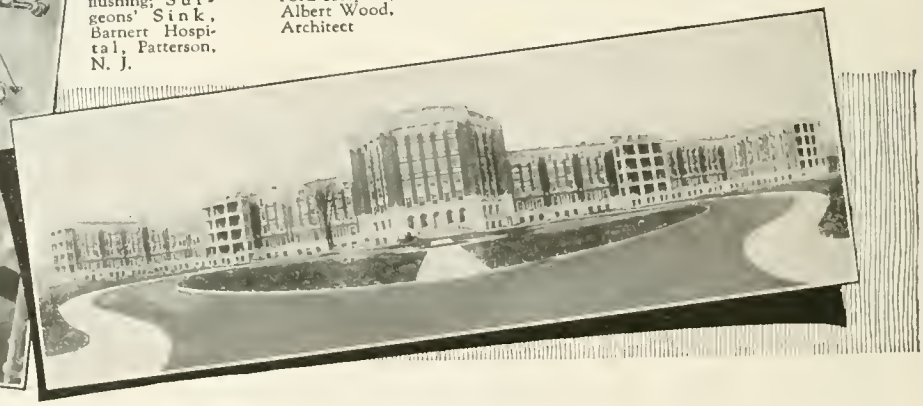

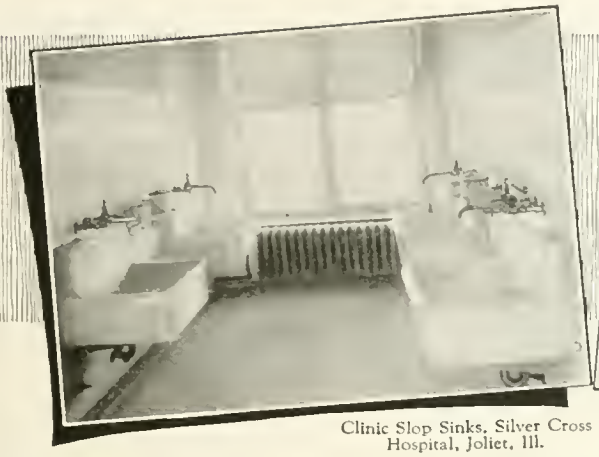

Clinic Slop Sinks, Silver Cross Hospital, Joliet, Ill.

Barnert Hospital, Patterson, N. J. F. W. Wentworth, Architect

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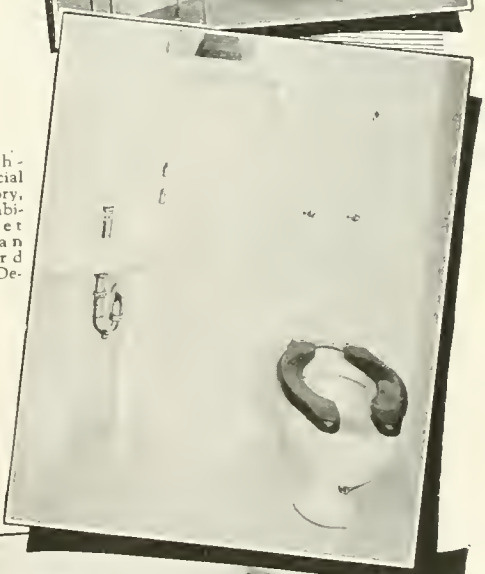
Vitroware Clinic Flushing Rim Slop Sink, Ann Camden, Memorial Hospital.



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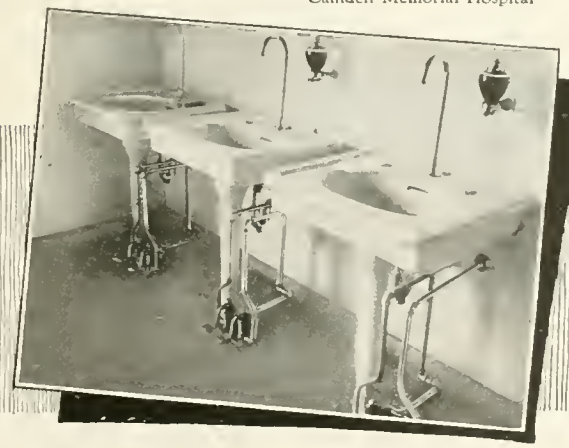

City Hospital, Jersey City, N. J. John T. Rowland, Jr. Architect

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St. Francis Hospital..... Hartford, Conn.
Hahnemann Hospital..... New York, N. Y.
St. Mary's Hospital..... Brooklyn, N. Y.
St. Vincent's Hospital..Staten Island, N. Y.
Atkinson Sanatorium..... Jersey City, N. J.
The Western Penn. Hospital..Pittsburgh, Pa.
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Children's Homeopathic Hospital..Phila., Pa.
Griffin Hospital ..... Derby, Conn.
Hahnemann Medical College & Hospital ..... Philadelphia, Pa.
Mercy Hospital ..... Baltimore, Md.
St. John's Hospital..... Brooklyn, N. Y.
St. Vincent's Hospital..... Sioux City, Iowa
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Noble Hospital ..... Westfield, Mass.

Brooklyn Hospital ..... Brooklyn, N. Y.
Women's Hospital of Phila..... Phila., Pa.
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Maternity Hospital ..... Johnstown, Pa.
Conemaugh Valley Memorial Hospital... ..... Johnstown, Pa.
The Manchester Memorial Hospital..... ..... South Manchester, Conn.
Sacred Heart Hospital..... Allentown, Pa.
Newton Hospital...Newton Lower Falls, Mass.
St. John's Hospital..... Lowell, Mass.
Lake View Hospital..... Danville, Ill.
New Borgess Hospital..... Kalamazoo, Mich.
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St. Joseph's Hospital ..... Menominee, Mich.
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THE RECEPTION COMMITTEE FROM THE INDIANA HOSPITAL ASSOCIATION

The following reception committee has been appointed by Dr. George F. Keiper, president of the Indiana Hospital Association, to welcome the members of the American Hospital Association to West Baden, and to do what they can to make their visit interesting and enjoyable.

Robert E. Neff, Robert W. Long Hospital, Indianapolis, Ind., chairman.
George F. Keiper, M.D., staff, St. Elizabeth Home and Hospital, LaFayette, Ind.
Clara E. Pound, Reid Hospital, Richmond, Ind.
W. O. Cross, M.D., Lutheran Hospital, Fort Wayne, Ind.
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F. B. Templin, M.D., Mercy Hospital, Gary, Ind.
Charles N. Combs, M.D., Union Hospital, Terre Haute, Ind.
L. L. Goepinger, Deaconess Hospital, Indianapolis, Ind.
Harry L. Foreman, M.D., City Hospital, Indianapolis, Ind.
Harriet Jones, Bloomington Hospital, Bloomington, Ind.
Mary E. McDonald, Elkhart Hospital, Elkhart, Ind.
Laura E. White, Goshen Hospital, Goshen, Ind.
Mrs. Alwight Hawks, Goshen Hospital, Goshen, Ind.
Lillian Barlow, Witham Hospital, Lebanon, Ind.
R. B. Wetherill, M. D., St. Elizabeth Hospital, LaFayette, Ind.
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Myrtle E. Elkins, Miami County Hospital, Peru, Ind.
Mattie Hemphill, Jasper County Hospital, Rensselaer, Ind.
M. F. Steele, M. D., Hope Methodist Hospital, Fort Wayne, Ind.
A. E. Morgan, M. D., Soldiers' Home Hospital, LaFayette, Ind.
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Maurice A. Rosenthal, M.D., St. Joseph's Hospital, Fort Wayne, Ind.
C. R. Shafer, M.D., Deaconess Hospital, Indianapolis, Ind.
A. E. Stern, M.D., "Norways," Indianapolis, Ind.
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Warren W. Lane, President, Home Hospital Board, LaFayette, Ind.

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This is the old-fashioned, w a s t e f u l, s l o p p y, unsanitary and expensive way of dispensing milk. In no case does it afford the proper percentage of butterfats with milk.

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American Hospital Association Convention

Sept. 12 to 16th
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There has long been a very great need for an urn that would serve milk containing the proper proportion of butterfats to milk in every serving until the last drop was used up. Until the advent of LYONS SANITARY MILK URN nothing had been discovered in the way of urns that would really solve this problem—that would prevent the first servings from getting only skim-milk from the bottom of the urn while the last few got all the rich cream.

Neither could bottled milk meet the problem, because the cost is excessive when compared with the cost of bulk milk.

The old method of dispensing milk from a can with the aid of a dipper or ladle was even more unsatisfactory for, while it merely reversed the process—giving the first few the cream and the remainder the thin milk—it was also wasteful, sloppy, unsanitary and withal, a very slow way to serve milk. (See opposite page.)

LYONS SANITARY COLD MILK URN PAYS FOR ITSELF

A few pounds of ice keeps the milk ice cold all day.

There is no slop or waste—The milk is never uncovered.

Five glasses can be drawn from the Urn to one the other way.

You can place a Lyons Urn anywhere and eliminate unnecessary handling.

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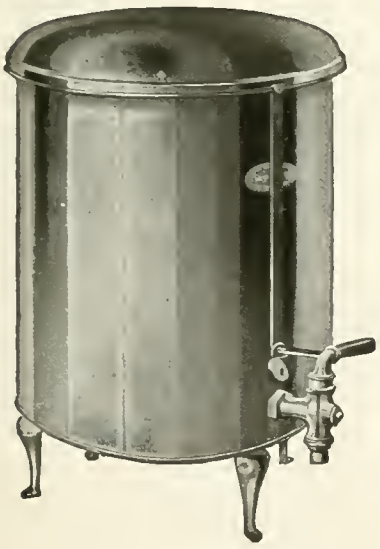
Lyons Sanitary Milk Urn is the only urn that dispenses milk containing the proper percentage of butter fats in each and every glass served, without any mixing or agitating mechanism, and it makes no difference whether the milk remains in the urn two minutes or two days. Place the day's supply of milk into the urn and draw it off through the faucet as you need it, and the milk will always be sweet, clean, cold and fresh.



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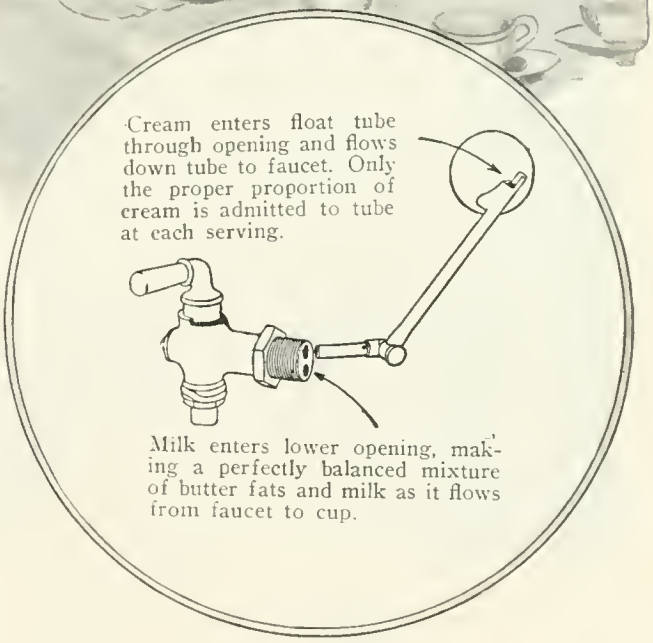
The New and Only Sanitary Economical Way


Cream enters float tube through opening and flows down tube to faucet. Only the proper proportion of cream is admitted to tube at each serving.
Milk enters lower opening, making a perfectly balanced mixture of butter fats and milk as it flows from faucet to cup.

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One of the MEN'S TOILET ROOMS

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A most complete and interesting display of Mott equipment will be made in the commercial exhibit and actual demonstrations given.

Your attention is cordially invited.

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ALL IN READINESS FOR THE A. H. A. CONVENTION

AS THIS issue goes to press, all arrangements have practically been completed for the Twenty-Third Annual Conference of the American Hospital Association, which will be held September 12 through 16, at the West Baden Springs Hotel, West Baden, Ind., and which promises to excel all previous conventions, both in attendance and in practical helpfulness.

As announced in the August issue of THE MODERN HOSPITAL, the newly organized Indiana Hospital Association will act as the host of the conference, and judging from the greeting, which appears on this page, extended to the delegates by Dr. George F. Keiper, the president of the Indiana Hospital Association, no stone will be left unturned to make the stay at West Baden a happy one.

The West Baden convention will be characterized by a number of commendable features. A great deal of thought has been given to the preparation of the program, despite the fact that there will be less than half the usual number of formal papers. Those who will read papers were chosen because they have a story worth telling, and they have been asked to tell that story and that alone. More time has been allotted for discussions.

Instead of a single round table discussion, such as has been so ably conducted by Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, at former conventions, there will be six round tables. One of the round tables will be devoted to the subject of general administration, and will be conducted by Dr. A. C. Bachmeyer, the able superintendent of the Cincinnati General Hospital. Dr. Bachmeyer's long years of experience at the Cincinnati General Hospital make him eminently qualified to conduct a round table on this particular subject. Mr. Asa S. Bacon, past master in the art of conducting round tables, will lead the discussion on departmental problems. Dr. George O'Hanlon, president-elect of the Association, who has been connected with Bellevue Hospital, New York City, during its period of reconstruction, will conduct the round table on construction problems, while Mr. John E. Ransom, superintendent, Michael Reese Dispensary, Chicago, well known in dispensary circles, will lead the discussion on out-patient problems. The round table on purchasing problems will be conducted by Mr. Guy J. Clark, the very efficient purchasing agent of the Cleveland Hospital Council. What Constitutes Good Service to the Patient will be discussed in the round table conducted by Dr. M. T. McEachern. These round tables will offer delegates an opportunity to present the problems that have been vexing them during the past year, with the assurance that definite help will be given them. Delegates are urged to formulate their questions in advance, and send them either to the office of the American Hospital Association, 22 East Ontario Street, Chicago, Ill., or to the chairman of the round table to which their questions pertain. No one need go home with any question unanswered.

Another outstanding feature of the convention will be the reports of the five special committees who have been at work during the past year, studying definite hospital problems with a view to standardizing hospital policy and procedure along these specific lines. The report of the special committee studying hospital forms and records, of which Dr. A. C. Bachmeyer is chairman, will undoubtedly arouse unusual interest, because of the practical character of the subject under study and the growing desire on the part of the hospitals for standard forms and records which will make possible comparative studies of hospital activities on a broad scale. Of equal interest, because of its practical character, will be the report of the special committee studying flooring materials for hospitals, of which Mr. Frank E. Chapman is chairman. This report will be based on a mass of data secured from hospital executives and hospital architects the country over, and will represent the most thorough study that has ever been made of this perplexing problem. Reports will also be submitted by the special committee on the subject of the relation between the hospital and the state and city, of which Mr. John E. Ransom is chairman; by the special committee for the study of state subsidy for hospitals, of which Mr. Howell Wright, secretary for the Cleveland Hospital Council, is chairman; and by the special committee studying the education of the hospital social worker, of which Mr. Michael M. Davis, Jr., executive secretary, Committee on Dispensary Development, New York City, is chairman. Through these studies it is hoped that certain definite standards of hospital administration and construction may be established, which will receive the official sanction of

TO THE AMERICAN HOSPITAL ASSOCIATION, GREETING:

It would seem as if for such a time as this the new Indiana Hospital Association was organized, first, to be able to act as host for the coming meeting of the American Hospital Association, in one of the beauty spots of America, West Baden Springs, Indiana, and second, that in its infancy, the Indiana Hospital Association may acquire, what it so much needs to give it a splendid start in life, the enthusiasm which this meeting of the American Hospital Association will engender.

So the Indiana Hospital Association bids you all welcome to our beautiful Indiana, and when you have seen us and ours, you will no longer wonder why we sing with zeal "Indiana" and "On the Banks of the Wabash far away."

Nestled amid the beautiful hills of Southern Indiana are the healing springs of West Baden and French Lick, whither thousands annually travel great distances in search of rest and health.

It is at West Baden, in its marvelous hostelry, that we await your coming. Everything will be done to contribute to your comfort and happiness during your too brief stay among us.

The Indiana Hospital Association is delighted that it has this privilege of acting as host on this auspicious occasion and participating in the furtherance of all our hospital interests so vast have they become.

The achievements of the past are but an earnest of those of the future. The hospital idea has not reached its acme of perfection. It has wondrously helped to make surgery safe and medicine effective. True it is today that the sick poor man has a better show for his life in a modern hospital than the sick rich man in the elegant appointments of a luxurious home.

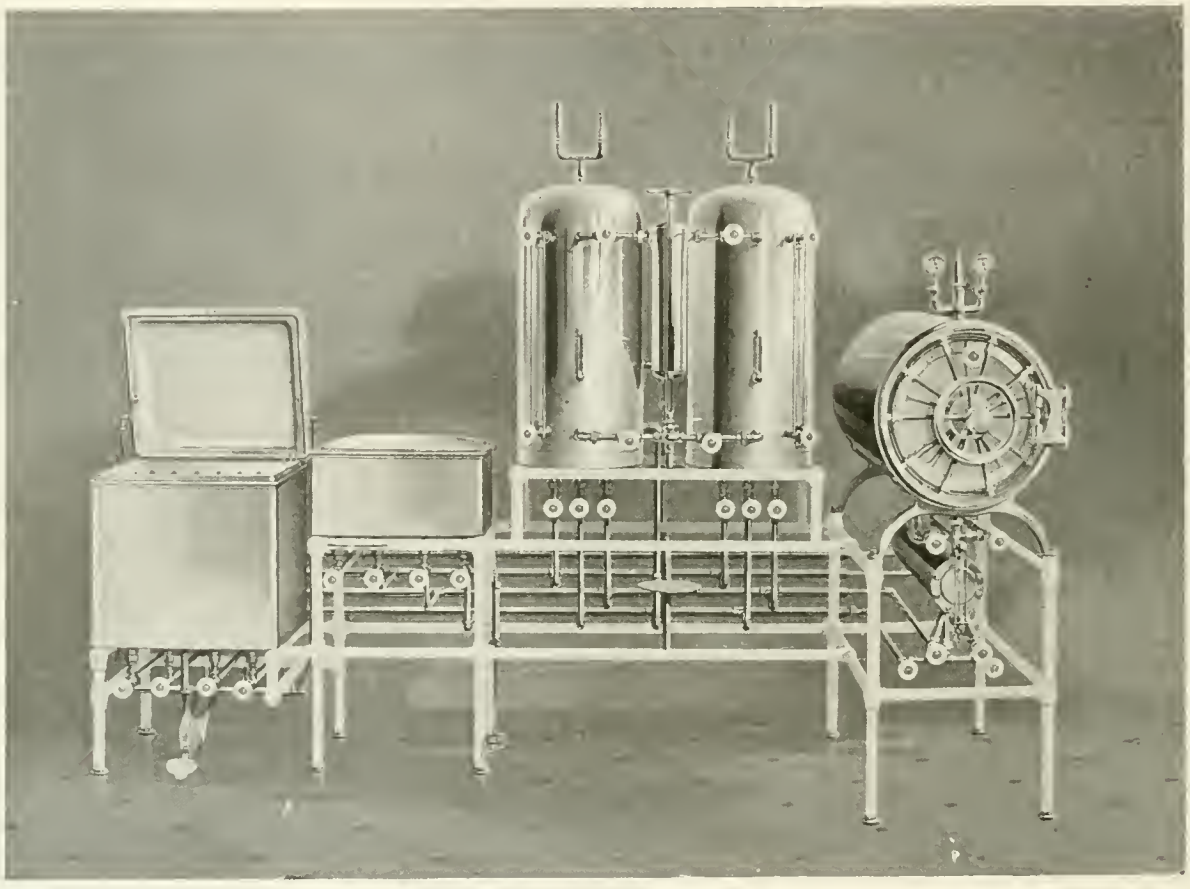
So come to Indiana and spend the week of September 12 to 16, in the beautiful surroundings of West Baden Springs, in preparation for greater usefulness in hospital service for all the people.

Welcome to Indiana—Our Indiana Home.

Hospitally yours,

GEO. F. KEIPER, President,
Indiana Hospital Association.

"White Line" Equipment



Battery of "White Line" Sterilizers

That quality which is built into hospital sterilizers will express itself in service after the equipment is installed in the hospital. "White Line" Equipment is built with this idea in mind.

Only the best materials are selected and used; materials that will withstand hard daily usage; materials such as when combined with experience and skill in construction, build a distinctive product.

Inspect "White Line" sterilizers and hospital equipment at the Exhibit of the American Hospital Association, Spaces 174-5.

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DR. LOUIS B. BALDWIN, President
Superintendent, University of Minneapolis Hospital, Minneapolis, Minn.

the Association. The importance of these reports to the hospital field can scarcely be over-estimated.

The smaller hospitals of the United States and Canada will receive a large share of attention. No little thought has been given to this aspect of the convention, and every effort will be made to make it distinctly helpful to the smaller institutions, an effort which, we understand, will not end with this year, for the Association is not unmindful of the fact that 60 per cent of our hospitals have less than one hundred beds.

Trustees Welcome Suggestions

As announced in our August issue, the trustees will hold an open meeting some time during the convention for the purpose of receiving and considering suggestions from members of the Association, relative to its work and progress. Members who have suggestions to offer are requested to submit them in writing if possible, for the trustees on this occasion. The time and place of this meeting will be announced at the convention.

Exposition Emphasizes Service

One of the most valuable features, from the service and education standpoint, will be the exposition of supplies and equipment. It will be fully twice as large this year as in any previous year, it will cover more of the hospital's needs, and every effort is being put forth by the Association to make the exposition of practical service to its members. Some conception of the magnitude of this exposition may be gained from the fact that it is conservatively estimated that $100,000 will be expended in its transportation, assembling, and operation.

Recreation in Abundance

While the convention will be essentially a working convention, opportunities for recreation are abundant. The series of articles on West Baden, which has been running in THE MODERN HOSPITAL, beginning with the July issue, should give to the delegates an excellent background for their visit to West Baden. As is pointed out in these articles, particularly the one which appears in this issue on "West Baden as It Is Today," page 206, there are on the hotel grounds, which comprise 640 acres, one of the best golf links in the country, tennis courts, a baseball diamond, bowling alleys, and facilities for other sports. Saddle horses are available, as well as automobiles. Beautiful walks and rides begin at the very door of the hotel.

Following the precedent established last year, the various service bureaus of the Association will have booths at the convention, to which delegates may resort for information and advice.

The service bureau of hospital social work will be glad to make special appointments with those who care to discuss any phase of hospital social work with experienced workers. An exhibit, showing the function, organization, and extent of hospital social service in this country, is being assembled for the meeting. Samples of records, statistics, forms and special literature will be available for those who care to see them. The bureau headquarters will also be the headquarters of the American Association of Hospital Social Workers.

The service bureau on dispensaries and community relations will hold regular office hours, at which delegates may consult Mr. Michael M. Davis, Jr., the director of the bureau, or one of his associates.

Library and Service Bureau to Have Exhibit

One of the features of the conference which will be distinctly helpful to many, will be the exhibit of the Hospital Library and Service Bureau. As indicated in the August issue of THE MODERN HOSPITAL, this exhibit will be made up of floor plans of hospitals, sanatoriums,

Cantilever Stores

Akron—II Orpheum Arcade
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Atlanta—Carlton Shoe & Clo. Co.
Austin—Carl H. Mueller
Baltimore—325 No. Charles St.
Battle Creek—Bahlman's Bootery
Birmingham—219 No. 19th St.
Boston—Jordan Marsh Co.
Bridgeport—W. K. Molan
Brooklyn—414 Fulton St.
Buffalo—639 Main St.
Butte—Hubert Shoe Co.
Charleston—J. F. Condon & Sons
Chicago—30 E. Randolph St.
Cincinnati—The McAlpin Co.
Cleveland—Graner-Powers Co.
Colorado Springs—Rich Shoe Co.
Columbus, Miss.—Simon Loeb's
Columbus, O.—The Union
Dallas—Leon Kahn Shoe Co.
Dayton—The Rike-Kumler Co
Denver—A. T. Lewis & Son
Des Moines—W. L. White Shoe Co.
Detroit—T. J. Jackson, 41 E. Adams Av.
Elizabeth—Gigl's, 1053 Elizabeth Av.
Elmira—C. W. O'Shea
El Paso—Popular D. G. Co.
Erie—Weschler Co.
Grand Rapids—Herpolsheimer Co.
Greenville, S. C.—Pollocks
Harrisburg—Orner's Boot Shop
Hartford—86 Pratt St.
Houston—Clayton's, 803 Main St
Huntington, W. Va.—McMahon-Diehl
Indianapolis—L. S. Ayres & Co
Jacksonville—Golden's Bootery
Kansas City, Kan.—Nelson Shoe Co.
Kansas City, Mo.—Jones Store Co.
Knoxville—Spence Shoe Co
Lancaster—Frey's, 3 E. King St.
Lincoln—Mayer Bros. Co.
Los Angeles—505 New Pantages Bldg.
Louisville—Boston Shoe Co
Macon—The Dannenberg Co.
Meridian—Winner, Klein & Co.
Milwaukee—Brouwer Shoe Co
Minneapolis—21 Eighth St. South
Missoula—Missoula Merc. Co.
Mobile—Level Best Shoe Store
Montgomery—Campbell Shoe Co.
Morristown—G. W. Mellck
Muncie—Miller's, 311 So. Walnut St.
Nashville—J. A. Meadors & Sons
Newark—Aeolian Hall (2nd floor)
New Haven—153 Court St.
New York—22 W. 39th St.
Omaha—1710 Howard St.
Philadelphia—1300 Walnut St.
Pittsburgh—The Rosenbaum Co.
Plainfield—M. C. Van Arsdale
Portland, Me.—Palmer Shoe Co.
Portland, Ore.—353 Alder St.
Providence—The Boston Store.
Reading—S. S. Schweriner
Richmond, Va.—S. Sycle, 11 W. Broad
Rochester—48 East Av.
Rockford—D. J. Stewart & Co
Salt Lake City—Walker Bros. Co.
Santa Barbara—Smith's Bootery
Savannah—Globe Shoe Co.
Schenectady—Patton & Hall
Seattle—Baxter & Baxter
Sioux City—Pelletier Co.
South Bend—Ellsworth Store
Spokane—The Crescent
Springfield, Mass.—Forbes & Wallace
Stamford—L. Spelke & Son
Syracuse—136 S. Salina St.
Tacoma—Fidelity Bldg
Tampa—Glenn's, 507 Franklin St.
Terre Haute—Otto C. Hornung
Toledo—Lasalle & Koch Co.
Trenton—H. M. Voorhees & Bro.
Tulsa—Lyons Shoe Store
Vancouver—Hudson's Bay Co.
Walla Walla—Gardner & Co
Washington—1319 F Street
Wichita—Rorabaugh D. G. Co.
Worcester—J. C. MacInnes Co.
Yakima—Kohls Shoe Co
Yonkers—Louis Klein, 22 Main St.
York—The Bon Ton
Youngstown—B. McManus Co.

Is it worth while?

WHEN you find that you tire easily, when happiness fails through headache, backache, nervousness—then ask yourself: "Is it worth while to wear harmful shoes?"

Physicians assert that the bad effects of wrongly shaped shoes are far-reaching. The unnatural posture induced by high heels throws the internal organs out of position. Resulting troubles often necessitate operations.

The woman who would be at her best and brightest will wear Cantilever Shoes. Their flexible arches, which conform to the natural action of the foot and allow the muscles free play, enable you to walk or stand correctly with minimum fatigue, and eliminate all danger of weak or fallen arches.

They stimulate—not retard—the circulation which brings to the cheeks a bewitching glow. They do not abuse the nerves which run from the feet up through the body even to the eyes. Knowing that your physical perfection starts with your feet, you can take satisfaction in the thought that your Cantilever Shoes conduce to your health and charm, your youthfulness and joy in living.

Good taste distinguishes every detail of Cantilever Shoes. They exemplify the fact that women and their shoes can be at once aensible and stylish.

If no dealer listed at the left is near you, write the Manufacturers, Morse & Burt Co., 1 Carlton Avenue, Brooklyn, N. Y., for the Cantilever Shoe Booklet and the address of a nearby dealer.

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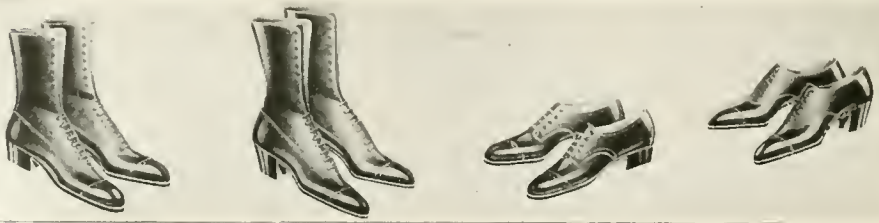

and dispensaries, nurses' homes, health centers, and allied institutions. This exhibit will also contain a very complete list of architects specializing in hospital construction, as well as a limited number of books, journals, reprints, and pamphlets on various phases of hospital construction, equipment, and administration. The library has now in preparation complete subject, author, title, and analytical indices of the various hospital journals, and such parts of these indices as are complete at the time of the conference will be included in the exhibit, together with copies of the journals indexed. Sets of record forms used in hospitals of various types and sizes will also be shown, together with various books on the classification of diseases. The purpose of this exhibit is to bring hospitals in contact with the service now being rendered by the Hospital Library and Service Bureau, and to acquaint them more fully with its purpose and scope.

Hotel Rates

As the West Baden Springs Hotel is a resort rather than a commercial hotel, the rooms are very large, and designed to accommodate two or more persons in individual beds. Although the hotel affords abundant accommodation for the convention, the American Hospital Association urges delegates not to occupy rooms alone, unless they specially desire to do so and are willing to pay the increased rates. Preference will be given to double reservations, which should be made direct to the hotel.

The facilities of the public health baths at the West Baden Springs Hotel, including shower, tub and special baths, will be available to the delegates. Consequently, the need for rooms with baths is not as urgent as it is in the ordinary hotel.

DR. M. T. MACEACHERN, Superintendent, Vancouver General Hospital, Vancouver, B. C., will conduct a round table on "What Constitutes Good Service to the Patient?"

DR. GEORGE O'HANLON
President-elect
Superintendent, Bellevue Hospital, New York City

Hotel rates are as follows:

WEST BADEN SPRINGS HOTEL—THE CONVENTION HEADQUARTERS
(Capacity 1,200)
American Plan—Per Day

Without Bath

	Single	*Double*
Rooms Facing Atrium, Hot and Cold Water Only	$ 7.00	$13.00
Rooms Facing Atrium, Toilet, Hot and Cold Water	8.00	15.00
Outside Rooms, Toilet, Hot and Cold Water	9.00	17.00
Outside Rooms, Toilet, Hot and Cold Water, Specially Appointed	9.50	18.00

With Bath

Rooms Facing Atrium	9.00	17.00
Outside Rooms	9 50	18.00
Outside Rooms, Specially Appointed	10.50	20.00
Tower De Luxe Rooms, en Suite	11.00 per person	
For meals only, per day	5.50 per person	

FRENCH LICK SPRINGS HOTEL
One mile from West Baden Springs Hotel—(Capacity 800).
Taxi Service—Fare, 25c.
American Plan—Per Day

	Single	*Double*
Rooms with running water only	$7.00	$12.00
Rooms with lavatory and toilet	$8 or $9	$14 or $16
Rooms with bath	$10, $12 or $15	$16, $18 or $20
Rooms with bath, DeLuxe Building, one or two persons		$22.00
Corner Rooms, DeLuxe Building, two persons		26.00

COLONIAL HOTEL
Just outside grounds of West Baden Springs Hotel—36 available rooms
European Plan

Single Rooms with bath	$2.00 and $2.50 per day
Double Rooms with bath	$3.50 and $4.50 per day

American Plan

Single (With meals at West)	$ 7.50 and $ 8.00 per day
Double (Baden Springs Hotel)	14.50 and 15.50 per day

HOMESTEAD HOTEL
Just outside grounds of West Baden Springs Hotel—75 available rooms
European Plan

Single Rooms, hot and cold running water	$1.00–$1.50 per day
Single Rooms, hot and cold running water and toilet	2.00 per day
Single Rooms, hot and cold running water and bath	2.50 per day
Double Rooms, hot and cold water	2.00– 3.00 per day
Double Rooms, hot and cold water and toilet	3.50 per day
Double Rooms, hot and cold water and bath	4.50 per day

SUTTON HOUSE
One block outside the grounds of the West Baden Springs Hotel
42 Rooms
European Plan

Single Rooms with baths	$1.00 per day
Double Rooms, with baths	2.00 per day

Reduced Railroad Rates

The American Hospital Association has issued certificates which entitle its members and the members of their

Straight Line Food Service

THE Drinkwater Food Cabinet and Truck is the straight line between kitchen range and final meal service. Eliminates reheating and rehandling of any sort, including the costly, unsanitary steam table:

Drinkwater Food Equipment is

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It is built in separate units which can be grouped in any combination to meet any food service conditions. Drinkwater Equipment consists of

An all-steel, ball-bearing truck, rear wheels of swivel type; an all-steel removable platform for raising cabinet elevation; sanitary, insulated metal cabinets of rigid construction; and four sizes of covered, seamless, cast-aluminum containers.

The cabinets are built in two sizes; the containers are of approximately 6.5, 7.5, 10, and 19 quarts capacity, respectively.

A small cabinet will handle a five hot dish meal for a 25 to 28 bed ward. The large cabinet has almost twice this capacity.

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families to purchase, outright, tickets at a fare and a half for the round trip. These certificates should be presented in purchasing tickets to West Baden. These tickets simply require stamping by the ticket agent at West Baden to show attendance at West Baden. Because of the recreational facilities which the hotel offers, the dates for the sale of tickets have been set for various sections of the country, making it possible to purchase tickets on these certificates so as to arrive at West Baden Thursday morning, September 8, to remain at West Baden over the week-end, leaving before midnight Thursday, September 22. All railroad lines running to West Baden are fully advised concerning this convention, and are prepared to operate the necessary equipment to give adequate accommodations to delegates traveling by all roads.

Stop-Over Possible

The ordinary stop-over time limits of railroad tickets will permit delegates to visit the hospitals of Chicago, Indianapolis, St. Louis, and Louisville, either going or coming from the convention. if they so desire. The fact that West Baden is away from any great hospital center does not, therefore, prevent delegates from seeing two or three first class hospitals on the trip. Our readers will find some of these hospitals described elsewhere in this issue. Delegates are cordially invited by the hospitals of these cities to stop over long enough to visit them. The Louisville Hospital Association especially extends a cordial invitation to members of the Association to arrange their itinerary so that they may stop off in Louisville and visit its hospitals. This invitation is signed by the Louisville City Hospital, the Jewish Hospital, John N. Norton Memorial Infirmary, St. Joseph's Infirmary, Deaconess Hospital, Sts. Mary and Elizabeth Hospital, and St. Anthony's Hospital.

S. G. DAVIDSON, M.D., Superintendent, Rockford Hospital, Rockford, Ill., will read a paper on "Dispensary Problems in the Small City."

CLINICAL AND ADMINISTRATIVE RECORD FORMS AND RECORD KEEPING

By A. R. WARNER, Executive Secretary, American Hospital Association, Chicago, Ill.

What the Report of the Special Committee of the American Hospital Association on This Subject Means to All Hospitals.

Why It Needs Your Consideration and Cooperation.

IT HAS been a matter of common regret that but little uniformity of method exists in the field of hospital administration. To remedy this, it has been suggested that a formulation and discussion of basic principles involved in various procedures be accomplished through the American Hospital Association, leading to a general acceptance of the same. The idea is that these be formulated slowly, wisely, and with free discussion as it becomes possible to assemble committees of the right persons, and as the necessary funds become available. Hospital authorities have constantly maintained an attitude of acceptance towards this idea, but as no correlated and workable program was heretofore presented, little progress could be made towards standard methods.

During the past year the necessary funds became available to the Association to carry out a study of the recording of the entire performance of the hospital, clinical, business, and administrative. The committtee was selected for the work with the idea of utilizing the best of previous work on this subject, of securing the utmost freedom from past traditions in the development of the principles, and of making the results entirely in harmony with the best and the most practical administrative policies.

The fund available was sufficient to permit meetings of the committee whenever and wherever it seemed advisable. It was sufficient to provide a full time secretary for the committee, to carry out all the details and push the work.

The committee in charge divided the problem into eight parts: (a) Accounting; (b) Purchasing and Insurance; (c) Administration; (d) Professional Service; (e) Training School for Nurses; (f) Social Service; (g) Out-Patient or Dispensary Service; (h) Library; (i) Analysis of Institutional Activity. Each of the divisions was assigned to every committee member in rotation. This method of successive investigation permitted a collective opinion and forced speed, and in June the committee began to arrange the completed segments. In the work sincere effort was made to avoid radical or untried schemes and to adhere closely to simplicity and good business usage. With few exceptions, the forms have been arranged to conform, both in size and ruling, to trade stock, for purposes of economy, as well as with the standard forms of binders and filing

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3-Piece Bed Weighs	150 lbs.
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Walls of tubing 2½ times as thick.
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More rigid, stands straight, will not dent or bend, holds enamel.
Enamel does not crack at joints.
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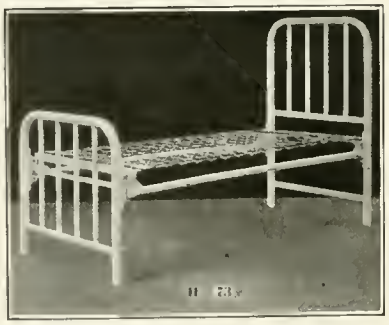

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ALICE M. GAGGS, Third Vice-President
Superintendent, John N. Norton Memorial Infirmary, Louisville, Ky.

cabinets. In presenting the data as a report, it became necessary to codify the contents. It was hoped that in so doing, a means would be created for extension or change as the future might demand. Institutions which desire to accept only a part of the system may easily do so, because the sections related by code will be found to form units designed to work harmoniously.

In its report the committee has named neither individuals nor institutions whose contributions in time, effort, and material have been so essential. To do so would be needless, as the report itself, incomplete as it is, indicates the universal cooperation given.

This report will be presented at the Annual Conference at West Baden for free discussion and for the approval of the Association. There will then be accepted principles governing the keeping of clinical and administrative records and approved form for the various procedures. It is expected that all recommendations will come into universal use, not because they will be better than the ones now in use in individual hospitals, but because they are declared by the official organization of hospitals, after free discussion, to be as good as any, with principles applicable to all hospitals. Isolation and individualism may delay the acceptance of some institutions, but the greater number will promptly welcome a "standard." This is one step toward solving the great handicap of the American hospital field—lack of uniformity in operating principles and practice.

ONE ROUND TABLE OMITTED

The 1921 Bulletin No. 3, issued to the personal members of the American Hospital Association called attention to the fact that at the Conference this year there would be five round tables instead of the usual one.

But one round table was inadvertently omitted from the list. There will also be a round table on the subject of "What constitutes good service to the patients," conducted by Dr. M. T. MacEachern of Vancouver, British Columbia. This is the crowning subject. Hospitals exist to give service to patients—better service than can be secured without them. The ultimate product of all hospital activities is good service to the patient, which includes the professional as well as the personal service.

Such service has its problems its questions and policies. It has been the main interest of the best minds in the hospital field in recent years. This cannot fail to be a most interesting session.

The correct list of the round tables this year is as follows: General Administration, Dr. A. C. Bachmeyer; Department Problems, Mr. Asa Bacon; Construction Problems, Dr. George O'Hanlon; Out-Patient Problems, Mr. John E. Ransom; Purchasing Problems, Mr. Guy J. Clark; What Constitutes Good Service to the Patient, Dr. M. T. MacEachern.

HOSPITAL SOCIAL WORKERS TO MEET AT WEST BADEN

At the semi-annual meeting of the American Hospital Association in September there will be, in addition to the business meeting, a program meeting and a luncheon. One section meeting is on social work. Mrs. Bess Lynde Russell, director of social service, Michael Reese Hospital and Dispensary, Chicago, is chairman of the program committee. Topics which will be presented are everyday questions on which everyone will be given an opportunity to express himself. For instance: "The Social Service Department as it Relates to the Administration," "The Social Service Department as it Relates to the Complete Treatment of the Hospital Patient," "The Social Service Department as the Hospital Listening Post in the Community," "A Social Worker's Day in an Out-Patient Department."

A. R. WARNER, M.D., Executive Secretary
American Hospital Association, Chicago, Ill.

HIGH-GRADE HOSPITAL SERVICE

is impossible without a correspondingly high-grade

NURSES' CALL SYSTEM

Superintendents, Visiting Physicians, and Architects owe it to themselves and to the helpless ones who entrust themselves to their care, to familiarize themselves with the

HOLTZER-CABOT CALL SYSTEMS

At Booth **No. 8** at the **West Baden Convention Exhibit** will be found a most complete and instructive exhibit of Holtzer-Cabot **Calling Systems, Annunciators, Bells,** etc. The exhibit is in charge of experienced engineers who have specialized in equipment of this nature. They will be glad to demonstrate the high-grade service which the Holtzer-Cabot product insures to patient and to hospital alike.

Page 472

THE HOLTZER-CABOT ELECTRIC COMPANY

Boston New York Baltimore Detroit St. Louis Minneapolis Chicago

INNOVATIONS MARK CONFERENCE PROGRAM

THE formal program of the Twenty-Third Annual Conference of the American Hospital Association is an unusually good one, and is characterized by several innovations.

There will be fewer formal papers and more time for discussion, and instead of one round table, as has been customary in previous years, there will be six. Special attention will be given to the problems of the smaller hospitals. Among subjects that will be discussed in formal papers are, "The Development of Good Professional Work in Hospitals," "The Contribution Which Hospital Records Can Make to Health Protection," "The Salaries of Hospital Superintendents," "Cooperative Purchasing," "Food Preservation."

The section on dispensaries, hospital construction, social service, administration, nursing, and dietetics will have helpful programs in their special fields.

Particular interest will center in the various reports of special committees, which have been at work during the year, studying specific hospital problems. A complete general session will be devoted to the presentation and discussion of these reports.

The Association has had an unusually active year, and the reports of the trustees and of the executive secretary, which will be submitted at the opening session, Tuesday morning, will reveal a number of noteworthy accomplishments.

Monday Afternoon

Monday afternoon, September 12, will be devoted to registration, and to the formal opening of the exposition of supplies and equipment, and delegates are urged to reach West Baden in ample time to visit the exposition before the formal opening of the convention. Monday evening will be devoted to a reception in the atrium of the hotel, at which there will be music and dancing.

Tuesday Morning

President L. B. Baldwin will open the convention formally at ten o'clock on Tuesday, September 13. Following the address of welcome, Dr. Baldwin will deliver the president's address. This will be followed by the reports of the trustees, the executive secretary, the treasurer, the membership committee, the service bureaus on dispensaries and hospital social work. After these reports have been submitted, Mr. Joseph J. Weber, managing editor of THE MODERN HOSPITAL, will read a paper on "Salaries Hospital Superintendents Are Now Receiving?" This paper will be based on information which has been secured from several hundred hospitals throughout the United States and Canada.

Tuesday Afternoon

The general session Tuesday afternoon will be devoted to a paper by Dr. Charles S. Woods, superintendent, Methodist Episcopal Hospital, Indianapolis, Ind., on "The Development of Good Professional Work in the Hospital." This paper will be followed by the first of the six round tables, which will be devoted to a consideration of what constitutes good service to the patient. It will be conducted by Dr. M. T. MacEachern, superintendent, Vancouver

DR. HAVEN EMERSON, Medical Adviser and Assistant Director, Bureau of War Risk Insurance, Washington, D. C., will read a paper on "How Hospital Records Can Contribute to Health Protection."

DR. CHARLES S. WOODS, Superintendent, Methodist Episcopal Hospital, Indianapolis, Ind., will read a paper on "The Development of Good Professional Work in the Hospital."

ARE YOUR PATIENTS COMFORTABLE?

The New Method

GASMASK RUBBER SHEETING

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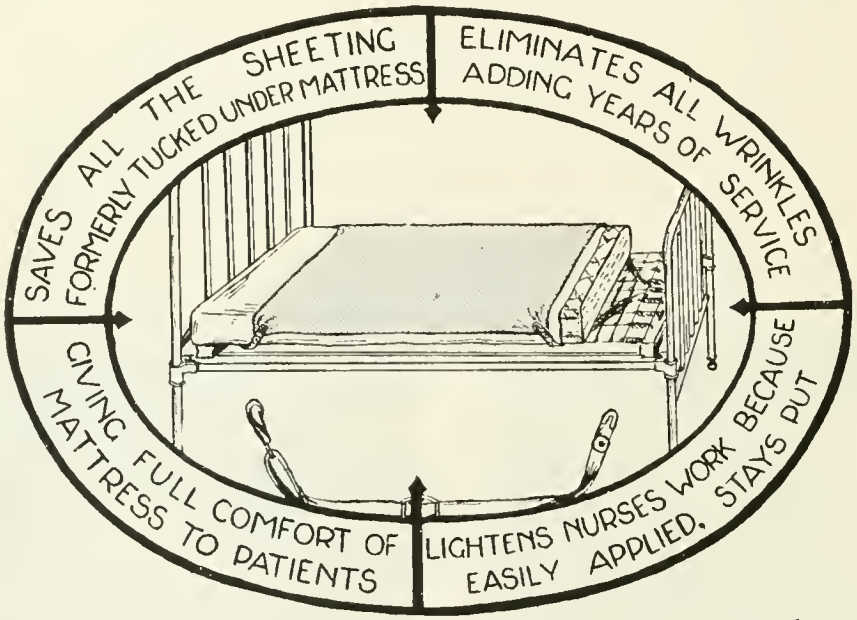
NORINKLE RUBBER SHEET STRAPS


SAVES ALL THE SHEETING FORMERLY TUCKED UNDER MATTRESS
ELIMINATES ALL WRINKLES ADDING YEARS OF SERVICE
GIVING FULL COMFORT OF MATTRESS TO PATIENTS
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Massachusetts Charitable Eye & Ear Infirmary.
Mt. Sinai, Cleveland, Ohio.
St. Alexis, Cleveland.
Highland Park General, Highland Park, Mich.
St. Vincent's Charity, Cleveland.
Salvation Army Hospital, New York.

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GAS MASK RUBBER SHEETING
APPLIED WITH NORINKLE STRAPS

FRANKLIN R. NUZUM, Medical Director, Santa Barbara Cottage Hospital, Santa Barbara, Cal., will discuss "A Method of Increasing Medical Efficiency Within the Hospital."

General Hospital, Vancouver, B. C. Dr. MacEachern's long experience at the Vancouver General Hospital, which renders an extensive service to a varied clientele, and his active participation in the standardization program of the American College of Surgeons in Canada, make him eminently qualified to act as the chairman of this round table.

Tuesday Evening

At the general session on Tuesday evening an innovation will be introduced. Dr. Haven Emerson, medical adviser and assistant director, Bureau of War Risk Insurance, will deliver an address.

Wednesday Morning

Wednesday morning's session will be devoted to meetings of the dispensary section and the hospital construction section, in the latter of which a round table on hospital construction problems will be conducted by the chairman of the section, Dr. George O'Hanlon. The dispensary section will be held under the chairmanship of Mr. John E. Ransom, superintendent, Michael Reese Dispensary, Chicago, Ill., and will be devoted to a three-fold discussion of the dispensary problems of the large city, the small city, and the rural community. The first topic will be discussed by Mr. Michael M. Davis, Jr., and the second by Dr. S. G. Davidson, superintendent of Rockford Hospital, Rockford, Ill. The third speaker has not yet been announced.

At the hospital construction section, which will be held in the Assembly Hall, Dr. George O'Hanlon will preside.

Wednesday Afternoon

Beginning at two o'clock, Wednesday afternoon, there will be a section meeting, and a round table discussion. The section meeting will be on administration, under the chairmanship of Dr. A. C. Bachmeyer. At this meeting Dr. Haven Emerson, medical advisor and assistant director, Bureau of War Risk Insurance, Washington, D. C., will deliver an address on "How Hospital Records Can Contribute to Health Protection." As health commissioner, New York City, and director of the Cleveland Hospital and Health Survey, Dr. Emerson has had an unusual opportunity of informing himself on this subject, and his address will be well worth listening to. Following this address there will be a general discussion on the report of the committee studying hospital forms and records from the administrative viewpoint. The general round table on departmental problems will be conducted by Mr. Asa S. Bacon.

Wednesday Evening

On Wednesday evening there will be three meetings, two beginning at eight o'clock, and the third at nine o'clock. The section on social service will meet in the assembly hall, under the chairmanship of Miss Ruth V. Emerson, secretary of the American Association for Social Service Workers. Miss Janet Thornton, now a member of the staff of the committee on dispensary development in New York City, will read a paper on "Hospital Social Service As It Relates to the Administration of Dispensaries," and Mrs. Bess Lynde Russell, director of social service, Michael Reese Hospital and Dispensary, Chicago, Ill., will discuss the subject of "The Hospital Social Service as it relates to the Medical Care of Patients."

In the convention hall there will be a general round table on administrative problems, conducted by Dr. A. C. Bachmeyer, and in the Moving Picture Hall there will be a special meeting for hospital trustees. The nine o'clock meeting will be a general round table and discussion on dispensary problems, conducted by Mr. John E. Ransom.

Thursday Morning

The section of nursing, Thursday morning, September 15, will be under the leadership of Miss Mary M. Riddle, superintendent, Newton General Hospital, Newton Lower Falls, Mass. Various topics relating to nursing will be presented in brief five to ten minute papers. Ample time will be given for discussion.

At ten o'clock there will also be a meeting of the American Conference on Hospital Service, of which Dr. Frank Billings, professor of medicine, University of Chicago, is president.

This meeting will open with a report and remarks by Dr. Billings. The report on the Hospital Library and Service Bureau will be submitted by Miss Donelda R. Hamlin, its director. Following this report, Dr. Harry E. Mock will submit his report as treasurer, and Dr. A. R. Warner, the acting secretary of the conference,

DR. FRANK BILLINGS
President, American Conference on Hospital Service
Professor of Medicine, University of Chicago, Chicago, Ill.

LIPPINCOTT'S

Nursing Manuals

Complete—Practical—Standard

Cooke's Handbook of Obstetrics COOKE

It is not merely a treatise on nursing but a work on obstetrics for nurses, giving all of the science and art of midwifery that a nurse need know, and should know, to practice her profession intelligently.

Surgical and Gynaecological Nursing PARKER

This practical work covers minutely every phase of the duties of the Gynæcological and Surgical nurse.
An unusual amount of space in text and illustrations is given to surgical instruments. For each operation instruments are laid out and photographed, numbered and named.

Materia Medica and Therapeutics FOOTE

Remedies have been classified in a logical therapeutic grouping, much material concerning methods of administration, definitions, prescriptions, and the newer remedies. The chapters dealing with the preparation of solutions and fractional doses will be found to be a comprehensive summary free from involved mathematics, making the teaching of this subject, usually so vexatious, a simple matter.

Essentials of Medicine EMERSON

As a text-book of medicine for nurses it takes rank in a place hitherto unfilled. It is clear, concise, simple and logical and presents the essential points and principles of medicine in an easily understandable and readily retainable form. The causes, reasons and effects of the various psychologic and pathologic processes taking place have been most lucidly given.

Care and Feeding of Infants and Children RAMSEY

This volume has been written as a text-book for nurses, and discusses the care not only of infants, but of older children. In addition to the ordinary subjects of infant feeding, we find a description of the various diseases of children and the general hygienic care required in their treatment.

State Board Questions and Answers FOOTE

This is a guide book to student nurses and their teachers.
The questions have been taken from actual State papers in thirty-one states and Canada, giving in a condensed form the general type of questions. This volume supplements but does not supplant text-books.

Write for illustrated descriptive circulars, teachers' copies, catalogs, to

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PHILADELPHIA, PA.

IDEAL
FOOD CONVEYOR

HAS been adopted by hundreds of hospitals throughout the country, after the most careful tests of its efficiency.

They have found that it greatly improves the hospital service in the serving of meals. It enables them to convey food direct from the central kitchen to the most distant wards without chilling or loss of fresh flavor.

It simplifies the serving of meals—holds food for 70 or 80 patients—eliminates much of the tray carrying that is so time-consuming.

The "IDEAL" Food Conveyor operates on the fireless cooker principles of heat retention. Is built for hard usage. Moves noiselessly on its rubber-tired, ball-bearing Colson wheels.

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Learn how the "Ideal" System of serving tempting meals can be applied to your food service. How the big savings it makes possible, quickly pay its cost. Write today.

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will read the report of the trustees. At this session the report of the special committee to work out the procedure in the determination of policies as to hospital service, will be submitted. The election of officers closes the session.

Thursday Afternoon

Thursday afternoon there will be a joint general session of the American Conference on Hospital Service and the American Hospital Association. At this time Mr. John G. Bowman, chancellor of the University of Pittsburgh, will deliver an address. The second and concluding address of this meeting will be delivered by Dr. Franklin R. Nuzum, medical director, Santa Barbara Cottage Hospital, Santa Barbara, Cal.

Thursday Evening

One of the most important meetings of the convention will occur on Thursday evening, at which time the report of various special committees, which have been at work during the past year, will be submitted to the Association. The report of the special committee studying flooring materials for hospitals, will be read by its chairman, Mr. Frank E. Chapman. The question of hospital floors has long been a mooted one, and this report should go a long way towards settling some of the problems involved in this question. Mr. John E. Ransom will submit the report of the special committee on the subject of the relation between the hospital and the state and city. Mr. Ransom has been in direct communication with appropriate city and state officials regarding this matter, and his report will be an unusually instructive one. The report of the special committee studying hospital forms and records will be read by Dr. A. C. Bachmeyer, the chairman of the committee. This committee has had special funds placed at its disposal to pursue this study, and its conclusions will deserve the careful consideration of the Association. It is hoped that as the result of this study certain fundamental principles will be evolved, and forms of records standardized for general adoption by the hospitals. Mr. Howell Wright, secretary of the Cleveland Hospital Council will submit the report of the special committee for the study of state subsidy for hospitals. The concluding report of this session will be a report of progress from the special committee studying the education of hospital social workers, of which Mr. Michael M. Davis, Jr., is chairman.

Friday Morning

At ten o'clock Friday morning the section on dietetics will conduct a general session, under the chairmanship of Miss Lulu G. Graves. Two papers will be read at this meeting, one on "Food Preservation," by John Phillips Street, of Indianapolis, Ind.; the other on "Practical Suggestions for Hospital Dietary Departments," by

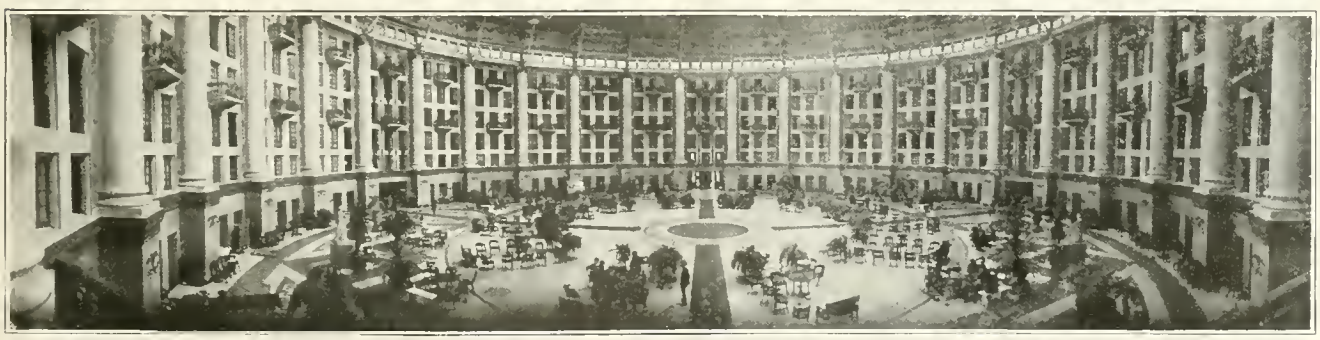
ASA S. BACON, Superintendent, Presbyterian Hospital, Chicago, Ill., will conduct a General Round Table, at which department problems will be presented and discussed.

Miss Rena Eckman, chief dietitian, University Hospital, Ann Arbor, Mich. At eleven o'clock there will be a general session, devoted to the subject of purchasing. Mr. Guy J. Clark, purchasing agent of the Cleveland Hospital Council, who is thoroughly informed on purchasing methods, will read a paper on "Cooperative Purchasing by Hospitals," after which he will conduct a round table, at which superintendents will have an opportunity to present their purchasing problems for discussion.

At 10 a. m. on Friday there will be an executive session of the American Conference on Hospital Service.

Friday Afternoon

The convention will close on Friday afternoon with a general session, at which Mr. R. M. Bradley of Boston, Mass., will deliver an address on "Where to Go for Money." His address will be followed by reports from the committees on constitution and by-laws, resolutions, time and place, auditing, nominating, and any special committee that may be appointed during the conference. Following the election of officers the new president will take the chair and barring any special business that may be presented, the Convention will then be brought to a close.



The Pompeian Room of the West Baden Springs Hotel

SUPER-EFFICIENT

THE above reproduction of photographs of Van's installation of a modern kitchen in the Municipal Contagious Disease Hospital in Chicago speak for themselves. They represent the ideal we always aim to realize in installations of equipment for the preparation and serving of food in institutions—achievement through cooperation of Architect, Builder, Sanitary Engineer and our own Food Service Experts. We can help you solve your problems of culinary equipment in an efficient and up-to-date manner. Write for Supplement A.

See our exhibit at the American Hospital Association Convention, West Baden, Sept. 12-16.

CHICAGO

The John Van Range Co.

EQUIPMENT FOR THE PREPARATION AND SERVING OF FOOD

Cincinnati

DETROIT

CLEVELAND

AUTOMOBILE ROUTES TO WEST BADEN

THE lure of the justly famed "white roads" of Indiana will undoubtedly induce many convention visitors to motor to West Baden. Weather and road conditions in Indiana are generally excellent in the fall, making September touring most enjoyable. Then, too, the scenic beauties of the semi-mountainous sections of southern Indiana give added zest to such a trip.

The route to West Baden from practically any section of the country will lead through one of five great centers, and for the convenience of prospective tourists, we are giving the preferred routes from these cities.

Chicago to West Baden

While several routes are available from Chicago, the majority of tourists will prefer the recently completed Dixie Highway, which gives an unbroken stretch of concrete for one hundred and thirty-four miles, from Chicago to Danville, Ill. From Danville two alternative routes are available. From road information recently gained, the desirable route will be directly south from Danville through Paris, Ill., and then diagonally to Terre Haute, Ind.; then along the Wabash Valley to Vincennes, a city of historical interest. Most of the roads over this route are gravel and macadam, and late reports indicate that they are in excellent condition. From Vincennes the route takes one in an easterly direction through an extremely picturesque country with many long grades and steep hills, but with many charming vistas to reward the tourists. The road from Vincennes to West Baden is almost entirely macadam and with the exception of "water bars" at some points, is reported in very good condition.

The alternative route from Danville leads east along the National Highway to Crawfordsville, then south over gravel roads to Greencastle, Spencer, Bloomington, and Bedford to West Baden. If desired, tourists can continue on the National Highway from Crawfordsville as far as Indianapolis and then follow the Indianapolis route given below to West Baden. Both of these routes, however, are somewhat longer than the preferred route through Terre Haute and Vincennes, and construction work may necessitate several detours. The distance from Chicago to West Baden by the more direct route is approximately 315 miles.

Indianapolis to West Baden

Many Ohio and Eastern tourists will approach West Baden through Indianapolis, as the state capital is the natural center of many important highways. From Indianapolis to West Baden there is an excellent highway, this being a continuance, for most of the distance, of the famous Dixie Highway. With the exception of a few miles of concrete, this route is almost entirely macadam and over an interesting and rolling country. From Indianapolis the route passes through Martinsville, the home of seven sanatoriums, Bloomington, where is located Indiana University, Bedford, noted for its building stone, and Paoli to West Baden. The distance from Indianapolis to West Baden via this route is 120 miles.

Cincinnati to West Baden

The majority of tourists who approach West Baden via Cincinnati will take the more direct of the two routes offered. Leaving Cincinnati, the Ohio river is followed through Lawrenceburg to Aurora, then a general westerly direction is taken, leading through North Vernon, Seymour to Bedford, and then south along the Indianapolis route to West Baden. Most of the route is over macadam roads and leads through an extremely interesting section of the state, the road winding between wooded hills. The distance via this route is approximately 165 miles.

While somewhat longer, many tourists will wish to go from Cincinnati via Indianapolis. This likewise is an excellent route. From Connersville, go through Bentonville and Carthage to Indianapolis, then follow the Indianapolis-West Baden route given above.

Louisville to West Baden

Tourists from the south will naturally approach West Baden via Louisville. At that point they will follow the old National Pike to West Baden. This is one of the historical roads of the country and an excellent macadam road, although caution should be used for frequent "water bars." The distance from Louisville to French Lick is about fifty-eight miles.

St. Louis to West Baden

St. Louis lies almost directly west of West Baden and the accepted route is via the Midland Trail to Vincennes where the Vincennes-West Baden route described before is picked up. Almost the entire distance from St. Louis to Vincennes is over black dirt roads which, when dry are easy driving, but become almost impassable after heavy rains. The distance from St. Louis to Vincennes is 155 miles and from Vincennes to West Baden sixty-four miles. As an alternative route from St. Louis, the National

One of the delightful surprises near the hotel—a fresh-water spring.

Irresistible trails to unknown spots are another attraction.

The S & S "Kensington" built for Milwaukee County Hospital

Designed by Superintendents in 48 States

TO THE building of the Kensington has been brought the practical experience of many hospital superintendents. In order that no essential to high class service might be overlooked, hospital superintendents all over the country were interviewed by S & S representatives.

The result is an ambulance incorporating all the good features and eliminating all objectionable ones as found in actual practice.

You will find in the Kensington every desirable detail; short turning radius, easy loading rear entrance, four side doors, special spring construction, 70 h. p. Sayers-Continental motor, Bomgardner adjustable cot, cord tires, floor heater, electric fan, Duplex headlamps, and an entire absence of unnecessary noise due to substantial construction. The car is finished inside and out in a pleasing manner which inspires confidence in the patient.

If you are interested in improved ambulance service you will enjoy reading our booklet describing this new car designed exclusively for hospital service.

See the S & S Exhibit at the American Hospital Association Convention, West Baden, September 12-15

The Sayers & Scovill Company

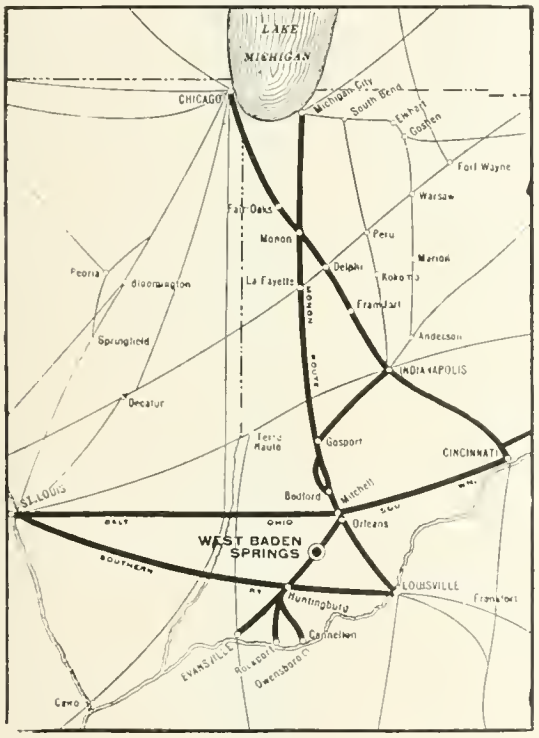
Established 1876 Cincinnati, Ohio

Highway can be followed through Vandalia, Effingham, to Terre Haute, and from Terre Haute the route given before, via Vincennes. This gives a greater mileage on hard roads, although sections of the National Highway between St. Louis and Terre Haute are under construction, necessitating frequent detours.

At West Baden ample garage facilities are provided, while numerous side trips of considerable interest will make the stay at the convention even more pleasant.

RAILROAD ROUTES AND RATES

Convention visitors will find West Baden readily accessible by rail from practically every point. Both the Monon and Southern Railroads have lines to West Baden, giving virtually direct connections from leading centers, such as Chicago, Indianapolis, Cincinnati, Louisville and St. Louis, and with the important railroads of the country which pass through these cities. Through Pullman service is maintained from Chicago and Louisville and by the co-



operation of connecting lines solid Pullmans can be handled from any part of the country. Hospital executives planning to go to the convention from any of the large centers are urged to get in touch with others from the same city and then take the matter up with their local railway officials. This will undoubtedly make it possible for delegates from eastern cities and from other large centers to enjoy through Pullman service direct to West Baden Springs.

Reduced Railroad Rates

The Association was able this year to secure a reduction in regular railroad fares to all members presenting certificates of membership. This enables all members and their families to secure the special rate of a fare and a half for the round trip. Before the return trip is made, the ticket must be stamped by the local agent at West Baden in order to show attendance at the convention. These special tickets will be on sale in your city so as to enable you to arrive at West Baden Saturday morning September 10, and to remain there over the week end, leaving by midnight, Thursday, September 22.

Railway officials on the lines giving direct connections to West Baden are making careful plans so as to insure prompt and comfortable handling of all delegates either from points on their line or beyond.

PROTESTANT HOSPITALS HOLD FIRST MEETING AT WEST BADEN

Monday, September 12, 1921

1:30 P.M. Opening Service, Convention Hall.
A. O. Fonkalsrud, M.D., Superintendent, St. Luke's Hospital, Fargo, N. D.

1:40 P.M. Address of President, Pliny O. Clark, Denver.

1:50 P.M. Report of Executive Secretary, Rev. Frank C. English, D. D., Cleveland, Ohio.

2:10 P.M. Business:

Discussion of Practical Problems

2:45 P.M. "Schools of Nursing as Educational Institutions."
Mrs. Ethel P. Clarke, Director, School of Nursing, University of Indiana.

3:00 P.M. Discussion.

3:15 P.M. "Executive Problems"—Selection of Trustees, their functions"
Joseph Purvis, Superintendent, Memphis Central Hospital, Memphis.

3:30 P.M. Discussion led by—
B. A. Wilkes, M. D., Superintendent, Missouri Baptist Sanitarium, St. Louis.

3:45 P.M. "The Financial Problems of Church Hospitals"
E. S. Gilmore, Superintendent, Wesley Memorial Hospital, Chicago.

4:00 P.M. Discussion.

4:15 P.M. Report of Committees:

4:45 P.M. Adjournment.

5:15 P.M. Round Table—Dinner.
F. C. English, Chairman.
This dinner will be served by the Hotel in one of the large dining rooms. Reservations should be made with the executive secretary.
General topic: "How can the Protestant Hospital Association best function?"

Evening Session

7:30 P.M. Devotional Service.
Rev. Carl V. Glick, Pastor, Methodist Episcopal Church, West Baden, Ind.

7:40 P.M. Business.

8:00 P.M. "The Call for Nurses for Home and Foreign Mission Hospitals"
Mrs. F. I. Johnson, Columbus, Ohio.

8:15 P.M. Address.
Adjournment.

Since this is the first meeting of this Association, a large attendance by representatives of all the Protestant hospitals, whether directly affiliated with any particular church or not, is expected.

The executive committee will present a proposed form of constitution and by-laws, and much important business will be before the convention for consideration.

The officers of the American Hospital Association have been very courteous and helpful in the making of arrangements for this convention, and since the sessions immediately precede those of that association, the additional expense for attendance will be merely the cost of your hotel accommodations.

All those proposing to attend the American Hospital Association convention are cordially invited to attend the meetings of the Protestant Association.

Standardization

YALE Quality Needles are standardized in two ways—each representing an important value to Hospitals and other users.

FIRST, the quality of YALE Needles is made uniform by applying every necessary process of manufacture, and by the most rigid inspection of each needle.

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The difference in price between YALE Needles and the cheapest needles obtainable does not justify the sacrifice of standardization.

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THE HOSPITAL EXPOSITION

IF arbitrary standards of quality were established in every line of merchandise, the problems of buying would become more nearly routine. Purchasing would resolve itself into a comparison of price and a decision as to the quantity needed. But, absolute standards of quality or value are established in only a few instances; in the majority of products, both are comparative.

Herein rests the great outstanding value of the hospital exposition to those executives responsible for the purchasing in their institution. The exposition affords opportunity to not only inspect, but what is much more important, to **compare** merchandise. It is virtually impossible for even the most skilled buyer to retain an exact idea of the quality of a product and make an intelligent comparison with the product of another firm after a lapse of several days, weeks or even months. It is nearly always possible to inspect merchandise offered for sale; at the exposition is afforded the opportunity of **comparing** the products of several companies offering products of similar nature.

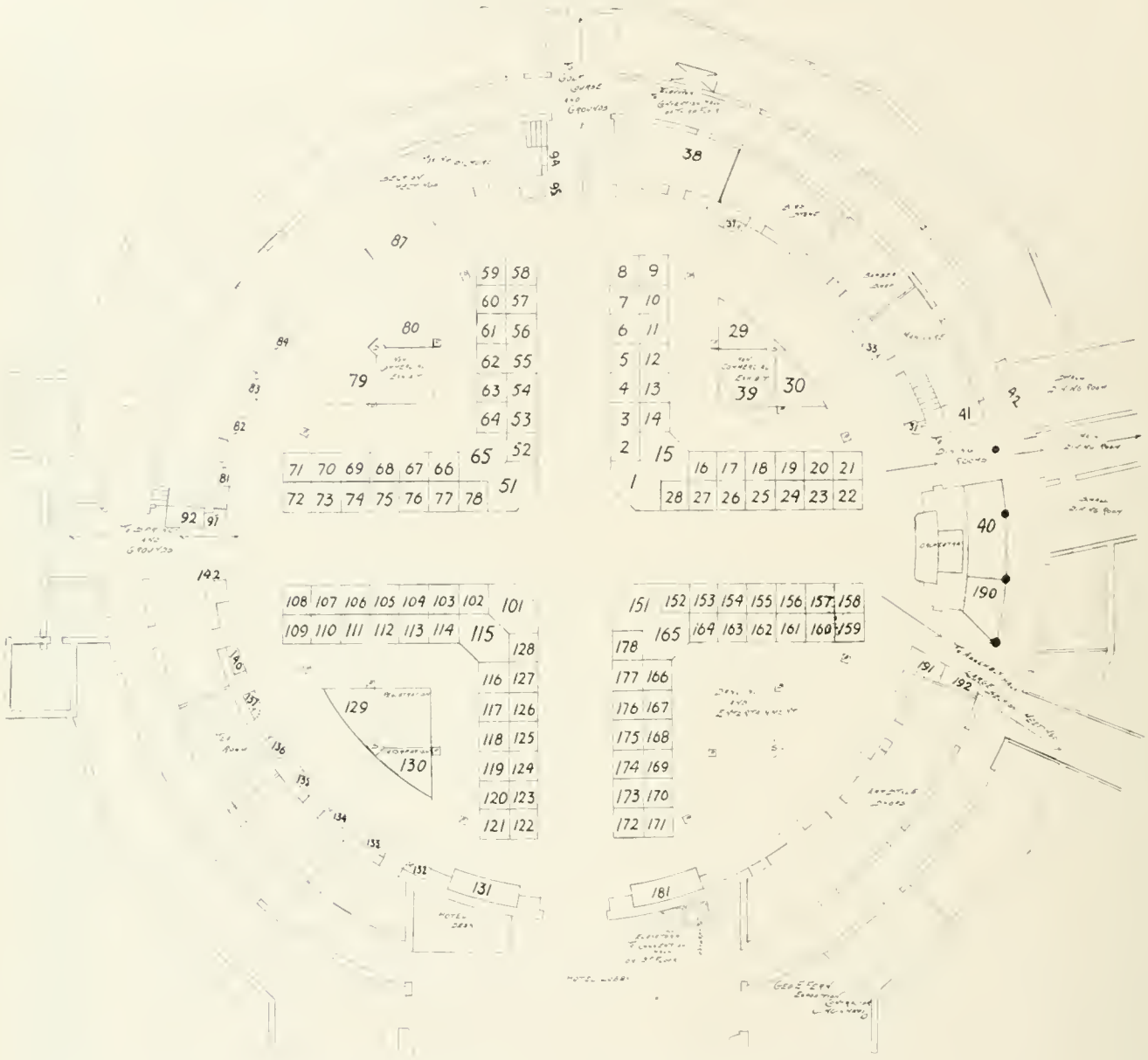
It was because of the full realization of this fact that the Association has exerted every effort to make the hospital exposition this year more complete, not only in the variety of exhibits, but in the number of exhibitors offering similar merchandise. If you are interested in bed or table linens, you can inspect the offerings of several concerns; surgical appliances and supplies will be shown by a considerable number, and full opportunity afforded for a comparison of the values offered and their adaptability to your institution. It is difficult to select the best labor saving kitchen appliances from merely a catalog description or the inspection of a single equipment. At the exposition, however, you can compare many labor saving devices and judge at first hand which is best suited to your needs. The same applies throughout the entire gamut of equipment and supplies used in your hospital. Not only can you inspect, but you can compare, and it is through intelligent comparison that successful purchasing is possible.

Progress in the designing and manufacture of hospital equipment is constant. New and improved devices, better quality, greater values are constantly being made available. It is only through the careful inspection of merchandise as exhibited at an exposition such as the one at West Baden that the buyer can keep completely abreast of progress. The information gained means actual saving to your institution, besides making possible greater efficiency and economy in operation.

Another opportunity which the exposition offers is that of direct contact with the leading experts in various lines. Business today is highly specialized and each manufacturing or merchandising concern has men on its staff who have made an intensive study of the hospital as related to their particular products. Many of these experts will be at the exposition. Hospital executives will have the benefit of their expert knowledge without obligation, and without commitment to the products of a particular concern. Whether the problems are connected with technical installations or with routine of service, there will be men qualified to advise authoritatively. Such counsel is of inestimable value. It gives the facilities of specialized knowledge enjoyed by only those who have made a life long study of the subject.

It is because of these definite advantages that every visitor at the convention is urged to come prepared to make the fullest possible use of the exposition. The Association offers you an unequalled opportunity. The benefits to be gained depend entirely upon yourself.

FLOOR PLAN OF HOSPITAL EXPOSITION



Alphabetical List of Exhibitors

Albatross Metal Furniture Co. Booth 85
Irrigating table.

Altro Mfg. Co. Booth 68
Mr. Edward Hochhauser in charge.
Hospital garments.

Altschul, A. H. Booth 69
Mr. David S. Altschul in charge.
Assisted by Mr. Harry Raphael.
Brushes.

Aluminum Cooking Utensil Co. Booth 163
Mr. P. J. Callan in charge.
Aluminum jacketed kettles, aluminum cooking utensils and trays.

American Laundry Machinery Co. Booths 105, 106, 111, 112
Mr. C. W. McCarty in charge.
Assisted by Mr. H. C. Troxell.
Laundry equipment, silver burnishing machine.

American Sterilizer Co. Booth 123
Mr. J. E. Hall in charge.
Dressing, water, instrument and utensil sterilizers.

American Surgical Specialty Co. Booth 58
Mr. W. J. Cameron in charge.
Electrically lighted diagnostic instruments.

Applegate Chemical Co. Booth 82-T
Mr. H. R. Applegate in charge.
Laundry marking inks and machines.

Athey Company 192
Mr. A. A. Morse in charge.
Metal weatherstrips, window shades.

Baker Linen Co., H. W. Booth 117
Mr. L. C. Walker in charge.
Bed and table linens, blankets and towels.

Becton, Dickinson & Co. Booth 109
Mr. O. R. Schwidetzky in charge, assisted by Mr. H. A. Moore.
Hypodermic syringes and needles, clinical thermometers and elastic bandages.

Betz Co., Frank S. Booths 151, 152, 165, 178
Mr. Earl D. Hood in charge.
Assisted by Mr. J. A. Padden and others.
Hospital furniture, surgical instruments and supplies, sterilizers.

Brown Body Corp. Booth 129
Mr. W. G. Schmunk in charge.
Ambulance body.

Brunswick-Balke-Collender Co. Booths 126, 127, 128
Whale-Bone-Ite seats.

Burdick Cabinet Co. Booth 75
Mr. H. N. Seversen in charge.
Therapeutic lamps and electric light bath cabinets.

Campbell Co., A. S. Booth 95
Mr. G. C. Austin in charge.
Cello Hot Water Bottle.

Campbell Electric Co. Booths 153, 154
Mr. Chas. E. Wentzel in charge.
X-Ray outfits.

Castle Co., Wilmot Booth 15
Mr. W. B. Underwood in charge.
Instrument, dressing, water and utensil sterilizers.

Central Scientific Co. Booths 59, 60
Mr. H. V. Caldwell in charge.
Laboratory equipment and supplies.

Century Machine Co., The Booth 11
Mr. Paul Esselborn in charge.
Assisted by Mr. F. W. Schimanski.
Combination mixing and kitchen machines.

Charles Manufacturing Company Booth 92
Ice chippers, window ventilators

Clarke Linen Co., O. S. Booth 124
Mr. Theo. D. Stern in charge.
Bed and table linens, blankets, towels, curtains and draperies.

Cleveland Hospital Council Booth 110
Coast Products Co. Booth 166
Mr. J. H. Damson and Mr. A. W. Boyson in charge.
Canned fruits and vegetables.

Colonial Hospital Supply Co. Booths 120,122
Mr. A. L. Towner in charge.
Assisted by Mr. F. G. McGaw.
Rubber goods, enamelware, surgical supplies and instruments.

Colson Co., The Booths 118, 125
Mr. A. A. Crooks in charge
Wheel chairs, trucks and rubber tired wheels.

Colt's Patent Fire Arms Mfg. Co. Booth 119
Mr. R. H. Libbey in charge.
Dish and silver cleaning machine.

Columbus Aseptic Furniture Co Booths 72, 73, 74
Mr. Leon B. Randle in charge.
Hospital furniture.

Crane Co., The Booths 126, 127, 128
Mr. J. A. Farley in charge.
Assisted by Mr. W. E. McGowan.
Hospital plumbing and hydrotherapeutic equipment.

Crescent Washing Machine Co. Booth 28
Mr. B. A. Watson in charge.
Dish washing equipment.

Deknatel & Son, J. A Booth 76
Mr George R. Dessart in charge, assisted by Miss Sullivan.
Identification necklaces.

Diack, Dr. A. W. Booth 31-T
Dr. A. W. Diack in charge.
Sterilizer control.

Dispensary Service Bureau Booths 79, 80
Mr. Michael M. Davis in charge.

Dougherty & Co., H. D Booths 16, 17, 18
Mr. H. A. Swenson in charge.
Assisted by Messrs Mitchell, Leinbaugh and Leavell.
Hospital furniture and supplies, beds and bedding.

Drinkwater Co., The Booth 164
Mr. R. M. Fullerton in charge
Food service equipment.

Edmands, Walter S Booth 169
Mr. Walter S. Edmands in charge.
Electric light bakers.

Eyster Linen Co., R. W. Booth 83-T
Mr. R. W. Eyster in charge.
Bed and table linens, blankets, towels and tray cloths.

Ford Co., J. B. Booth 54
Mr. F. A. Merrick in charge.
Assisted by Mr. E. J. Small.
Laundry supplies.

General Motors Truck Co. Booth 173
Mr. J. E. Kilbourn in charge.
Ambulances.

Genesee Pure Food Co. Booths 77, 78
Mrs. J. S. Goldsmith in charge.
Jell-O.

Globe-Wernicke Co. Booths 20, 21, 22, 23
Mr. O. J. Dreyer in charge, assisted by Mr. H. W. Wittstein.
Record forms, filing devices, office furniture.

Goddard Rubber Co. Booth 71
Dr. W. E. Goddard in charge
Rubber goods.

Gumpert Co., S Booths 159, 160
Mr. T. Schumm in charge.
Chocolate puddings.

Hall & Sons, Frank A. Booths 176, 177
Mr. Frank W. Hall in charge.
Hospital beds and accessories.

Hobart Mfg. Co. Booth 124
Mr. Paul Yount in charge.
Mixing and kitchen machines.

Holtzer-Cabot Electric Co. Booth 8
Mr. Irwin Hickman in charge.
Nurses' call system.

Horlick's Malted Milk Co. Booth 172
Mr. G. A. Glasgow in charge.
Assisted by Misses Julia Runkel and Louise Rowan.
Malted milk

Hospital Library and Service Bureau Booth 39
Miss D. R. Hamlin in charge.

Hospital Equipment Bureau Booth 91
Mr. Chas. A. Friedman in charge.
Hospital supplies.

Hospital Management Booth 137-T
Publication.

Hospital Nurses' Uniform Mfg. Co. Booth 66
Mr. M. Wahn, Jr., in charge.
Hospital garments.

Hospital Social Service Quarterly Booth 133-T
Publication.

Hospital Supply Co. Booths 101, 115
Mr. W. G. Watters or Mr. Albert Graupe in charge.
Hospital and surgical supplies and equipment.
Sterilizers and disinfectors.

Hygienic Brush Co. Booth 142
Mr. A. M. Levis and Mr. L. Gleichenhause in charge.
Brushes and mops.

Hygienic Fibre Co. Booth 63
Cotton and gauze.

Indiana Hospital Association Booth 130
Miss Anna Medendorph in charge.

Jaeger-Bigelow Co. Booths 120, 122
Sutures and ligatures.

Kaufmann, Henry L. Booth 33-T
Mr. Henry L. Kaufmann in charge.
Rubber sheeting and Norinkle straps.

Kawneer Mfg. Co., The Booth 107
Mr. H. L. Owen in charge.
Simplex reversible window fixtures.

Kny-Scheerer Corp. Booths 104, 113
Mr. W. J. Weglener and Mr. R. R. Dower in charge.
Hospital furniture and sterilizers.

Kolynos Co., The. Booth 155
Mr. Ira D. Joel in charge.
Assisted by Mr. J. R. McClelland and Dr. W. L. Beecher.
Dentifrices.

Lane & Brothers, W. T. Booth 2
Mr. F. S. King in charge.
Laundry baskets, trucks.

Leonard-Rooke Co. Booth 57
Mr. F. C. Leonard in charge.
Water mixing valves.

Lewis Mfg. Co. Booth 19
Mr. Lawrence Davis in charge.
Assisted by Messrs. H. R Lane, H. G. Kilbourn, F. S. Wellman, H. W. Cole and W. J. Burke.
Cotton and gauze bandages, dressings, plasters and cellucotton.

Lippincott Co., J. B. Booth 170
Mr. W. A. Widmer in charge.
Hospital and nurses' books and anatomical charts.

Lowenfels & Co., Inc., B. Booth 181
Mr. Duncan MacLaren in charge.
Bed and table linens, blankets and towels.

Lyons Sanitary Urn Co., Inc. Booth 116
Mr. Harry G. Lyons in charge.
Milk and cream dispensers.

Macmillan Co., The Booth 81-T
Mr. J. H. Morehouse in charge.
Assisted by Mr. J. N. Myers.
Books on nursing and allied subjects.

Massillon Rubber Co., The Booth 171
Mr. and Mrs. S. B. Hankins in charge.
Rubber gloves and drainage tubing.

Mead Johnson & Co. Booth 156
Mr. E. M. Johnson, Jr., in charge.
Assisted by Mr. J. J. Quilligan.
Infant diet material.

Meinecke & Co. Booths 157, 158
Mr. Edward Johnson in charge.
Hospital and surgical supplies.

Metropolitan Hospital Supply Co. Booth 103
Mr. S. S. Fengel in charge.
Assisted by Mr. Frank Markoff.
Surgical supplies and equipment.

Michigan Hospital Association Booth 135-T
Mr. Durand W. Springer in charge.

Modern Hospital Publishing Co., The Booth 132-T
Publication.

Morris Hospital Supply Co. Booth 55
Mr. M. Morris in charge.
Assisted by Mr. A. W. Young.
Rubber goods, enamelware, surgical instruments and supplies.

Morse & Burt Co Booth 14
Miss Caroline Dexter in charge.
Cantilever shoe.

Mott Iron Works, J. L. Booth 38
Mr. E. L. Penfrase in charge.
Assisted by Mr. R. J. Shively.
Plumbing equipment and hydrotherapeutic apparatus.

Ohio Hospital Association Booth 136-T
Mr. F. E. Chapman in charge.

Pfaudler Co., The Booth 27
Messrs. Chase and Gray in charge.
Laundry chutes.

Pick & Co., Albert Booths 4, 5, 12, 13
Mr. Frank L. Fischer in charge.
Kitchen equipment, linens, general furnishings.

Pooler Lumber & Mfg. Co., W. J. Booth 42
Mr. R. F. Malone in charge.
Reclining chair.

Radium Co. of Colorado Booth 114
Mr. P. J. Carroll in charge.
Radium.

Randles Mfg. Co. Booth 41
Mr. Chas D. Randles in charge.
Nurses' uniforms and hospital supplies.

Read Machinery Co. Booths, 52, 53
Mr. O. N. Read in charge.
Mixing and kitchen machines.

Rhoads & Co. Booth 56
Mr. J. R. Rhoads in charge.
Bed and table linens, towels, blankets, hospital garments and piece goods.

Rolup Screen Co Booth 131
Mr. Hume Hickey in charge.
Window screens and awnings.

Ross, Will Booth 70
Mr. Will Ross in charge.
General surgical supplies, hospital trays.

Safety Anesthesia Apparatus Co. Booth 84-T
Mr. D. G. McCurdy in charge.
Apparatus for anesthesia.

Sayers & Scovill Co. Hotel Entrance
Mr. C. A. Eisenhardt in charge.
Assisted by Mr. E. E. Hess and Mr. J. Z. Miller.
Ambulances.

Scanlan-Morris Co. Booths 174, 175
Mr. S. G. Scanlan in charge.
Assisted by Mr. Wm. Herzog, Mr. T. J. Rudesill and Mr. C. S. Brown.
Hospital furniture, high pressure sterilizers.

Sexton & Company, John. Booth 1
Mr. Sherman Sexton in charge.
Canned fruits and vegetables, general food products.

Siebrandt Mfg. Co., J. R. Booth 110
Mr. J. R. Siebrandt in charge.
Extension splints.

Simmons Co. Booths 40, 190
Mr. B. J. Flynn in charge.
Hospital beds, mattresses, springs and accessories.

Stedman Products Co. Booth 10
Mr. James H. Stedman in charge.
Assisted by Mr. E. C. Kavanagh.
Naturized rubber flooring.

Surgical Selling Co., The Booth 64
Dr. R. H. Enzor in charge.
Assisted by Mr. J. N. Reisman.
Surgical supplies.

Taylor Instrument Companies Booth 7
Mr. T. M. Stewart in charge.
Sphygmomanometers, urinalysis glassware, barometers and thermometers.

Thorner Bros. Booths 51, 65
Mr. E. G. Thorner in charge.
Assisted by Mr. C. J. Meyer, Mr. S. Goldberg, Mr. P. D. Thorner, Mr. M. V. Papps and Mr. A. Klausner.
Hospital supplies, silverware, coffee and tea service sets.

Toledo Cooker Co. Booth 161
Mr. J. B. Swartzbaugh and Mr. D. D. Ludlow in charge.
Food Conveyors.

Trained Nurse & Hospital Review Booth 37-T
Publication.

U-File-M Binder Mfg. Co. Booth 162
Mr. H. G. Gurney in charge.
Filing devices.

U. S. Industrial Alcohol Co. Booth 108
Mr. E. Jourdain in charge.
Alcorub and alcohol.

Universal Rubber Corp. Booth 87
Mr. C. D. Conner in charge.
Rubber goods.

Van Range Co., John Booth 9
Mr. Daniel Metz in charge.
Kitchen equipment and supplies.

Waters-Genter Co. Booth 6
Mr. H. C. Genter in charge, assisted by Mr. F. C. Oliver.
Automatic Electric Toaster.

Weissfeld Brothers Booth 62
Mr. H. Weissfeld in charge.
Hospital garments.

White Co., The Booth 129
Messrs. H. S. Jenkins and D. B. Bugg in charge.
Ambulance.

Wilson Laboratories Booth 26
Mr. J. W. Burns in charge.
Assisted by Dr. David Klein and Mr. Victor S. Brock.
Glandular derivatives, digestive ferments, sutures and ligatures.

Wisconsin Hospital Association Booth 134-T
Dr. C. W. Munger in charge.

Wocher & Son Co., Max Booths 24, 25
Mr. Max Schmidt in charge.
Hospital furniture, instruments and supplies.

BUYERS GUIDE TO HOSPITAL EXPOSITION

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Aluminum Cooking Utensil Co. ..... Booth 163

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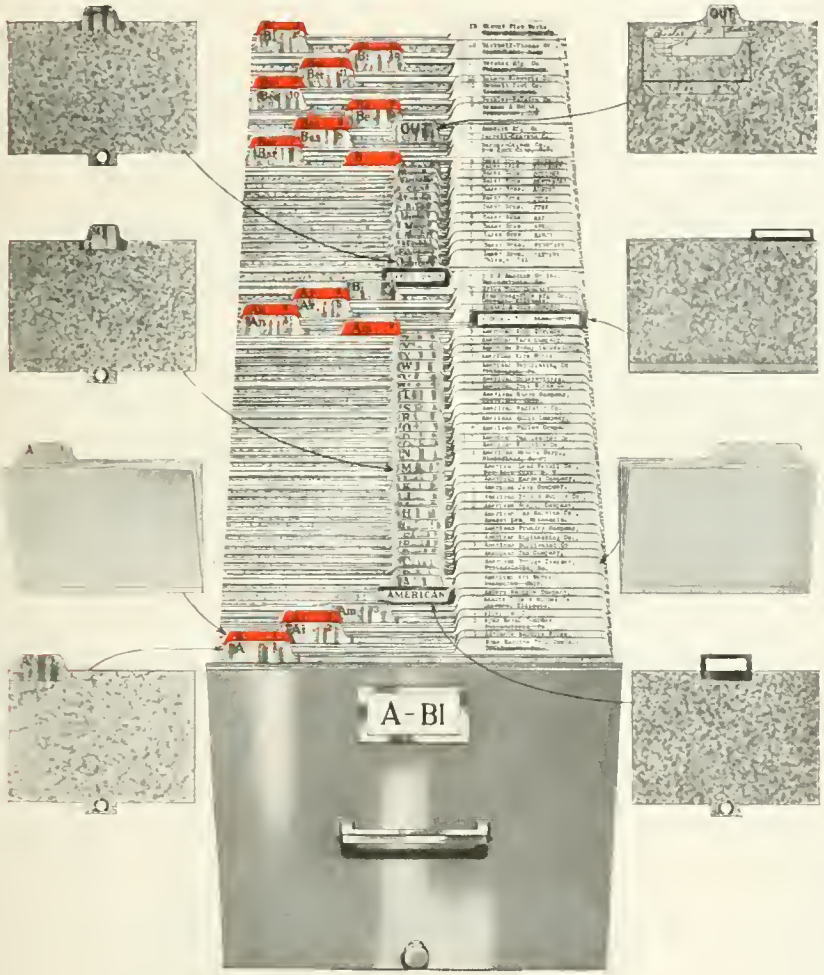

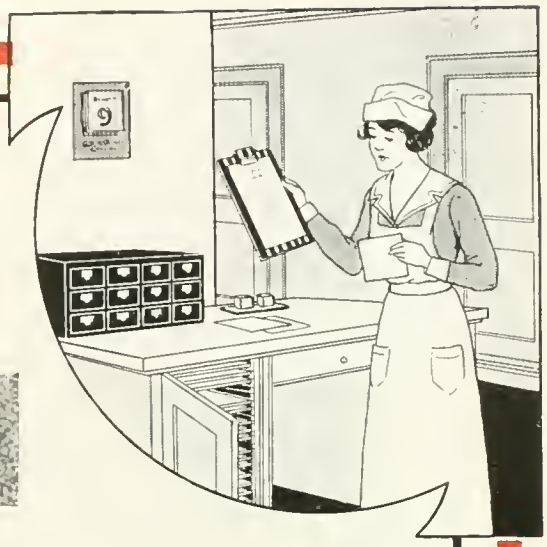

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HOSPITALS TO VISIT ON YOUR TRIP TO OR FROM WEST BADEN

IN GOING to or returning from the convention, members of the American Hospital Association will pass through Chicago, St. Louis, Indianapolis, or Louisville. This will give them an opportunity to visit some of the hospitals in these cities, if they so desire. All have extended to the delegates a hearty invitation.

THE MODERN HOSPITAL *takes this opportunity of presenting its readers with brief, illustrated sketches of some of the hospitals in these four cities. Our only regret is that lack of space forbids a more extensive description of these institutions, and the inclusion of a number of additional ones.*

EDITOR.

CHICAGO HOSPITALS

PRESBYTERIAN HOSPITAL, CHICAGO

The medical staff of the Presbyterian Hospital gives unusually careful attention to educational work and to the research laboratories, where all scientific investigations and tests are made. The laboratories are fully equipped, and under the supervision of experts. The hospital originated with the trustees and faculty of Rush Medical College in 1879, who at that time purchased a site for a hospital and voted to raise $15,000 for the erection of a building. Having in mind that there was only one protestant hospital (St. Lukes) in the city, the authorities of the college decided to try to interest in the project the Presbyterian churches of Chicago. The result of their efforts was that the Presbyterian Hospital Society was incorporated in 1883, to which society the trustees of the college deeded the lot which had been purchased, and the unfinished building, upon which $25,000 had been expended. Plans for a modern hospital were adopted, and the co-operation of the Presbyterian churches in the city was enlisted. From that time to the present the hospital has shown a steady growth. In 1912 the old building was replaced by one of modern, fireproof construction, which, with the equipment, cost $2,800,000. The training school for nurses, which was organized when the hospital was first opened, but was later discontinued, was permanently established in 1904.

WESLEY MEMORIAL HOSPITAL, CHICAGO

An unusual feature of Wesley Memorial Hospital is the fact that many of the staff men have offices and laboratory equipment in the hospital, ante-dating the time when hospital physicians will office exclusively in the institution where their work is performed. In addition to the regular equipment of x-ray and pathological laboratories the hospital has well equipped physiological, chemistry, and electrocardiographic laboratories. Wesley Hospital is associated with Northwestern University, its medical staff of about one hundred being drawn from the University medical faculty. Plans are now being prepared for a new nurses' home which will cost $100,000, and for which the land has already been purchased.

MICHAEL REESE HOSPITAL, CHICAGO

Michael Reese Hospital, with its staff of forty-eight physicians, accommodates almost every type of patient. In the dispensary during the year 1920, 49,642 patients were cared for. A new branch of the hospital work was started this year when a tonsil and adenoid clinic was established in a renovated settlement house in the Ghetto district. The hospital was founded in 1867 by the United Hebrew Relief Association of Chicago, and is now supported as a private philanthropic institution by the Associated Jewish Charities of Chicago. Ten years of the hospital's life were lost on account of the Chicago fire, the original building being destroyed in 1871 and the new building not being opened until 1881.

CHICAGO HOSPITALS

ST. LUKE'S HOSPITAL, CHICAGO

An interesting phase of the work of St. Luke's, a hospital established in 1864, is the prenatal clinic, which is large and constantly increasing. The hospital has a capacity of 400 beds, 127 of which are placed in private rooms, in the private patient building known as the "George Smith Memorial." A training school for nurses was established in 1885. It is now in a new building, and a dormitory for the nurses was purchased just north of the hospital. Clinics are given for the students of The Northwestern University and the University of Illinois. A large accident service in connection with the city ambulances is a feature of the service. The laboratories receive special consideration and productive research work is continuous. The training school for nurses, an integral part of the hospital corporation, normally has 180 pupil nurses and twenty-four officers and instructors. The school term is three years. The department of social service is extremely active, confining its efforts to the medical aspect of all cases unless in unusual cases there is no other agency to meet the situation. Cooperation with all social agencies is the aim throughout the work. The department of occupational therapy has made a place for itself and presents a most interesting phase of hospital work.

CHICAGO LYING-IN HOSPITAL

The beginning of the Chicago Lying-In Hospital was made in a four-room tenement in the poorest district of Chicago, the women being cared for in their own homes. A long step from that to the present building, which accommodates 150 mothers and 150 babies! One of the main objects of the hospital is the teaching of good obstetrics, which is done through the special training given to interns, students, and nurses.

MERCY HOSPITAL, CHICAGO

Mercy Hospital is called the pioneer of the hospitals, not only of Chicago, but of the Central West. Since its establishment, in 1849, as the "Illinois Hospital of the Lakes," it has kept pace with the progress in medicine and surgery. New buildings have been built, and additions made at intervals up to the present. The hospital prides itself upon the absence of gloom within its doors, and the fact that the oft-encountered "hospital atmosphere" is replaced by that of a well-appointed hotel.

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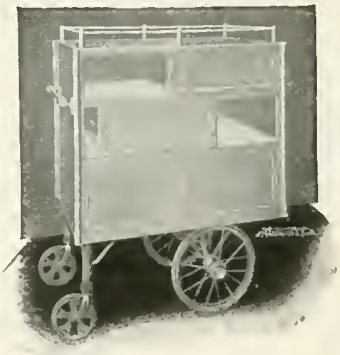

CHICAGO AND ST. LOUIS HOSPITALS

ENGLEWOOD HOSPITAL, CHICAGO

In thirty-two years the bed capacity of this hospital has grown from 5 to 150 beds. The hospital has recently constructed a new nurses' home, with accommodations for 85 nurses. The superintendent boasts especially of the hospital's simple but efficient record system. It is interesting to note that last year 15 per cent of the work of this hospital, which is without endowment and ended the year without a deficit, was charitable work.

ST. JOSEPH'S HOSPITAL, CHICAGO

The Chicago fire spared this hospital, which was established in 1868, and the city called upon its management to take charge of the "Barracks Hospital," which was built for the care of the poor in the devastated districts. Additions have been made from time to time to the original building, the most important being erected in 1914, until the hospital has a capacity of 200 beds. The Sisters, medical staff and nurses of this hospital trained the first class of the American Red Cross, organized in Chicago during the late war, and many of the personnel held responsible positions in war hospitals.

ST. LOUIS HOSPITALS

U. S. PUBLIC HEALTH SERVICE HOSPITAL NO. 35, ST. LOUIS

On July 1, 1919, the Public Health Service took over the Army General Hospital No. 40, located on Arsenal Street, which has since been known as United States Public Health Service Hospital No. 35, for the care of disabled ex-service men. Since that date the United States Marine Hospital has been used exclusively for the diagnosis and treatment of tuberculosis, while the one on Arsenal Street is used as a general hospital. The former has a capacity of seventy beds, the latter of 650 beds.

CASTLE

An opportunity for you

EVERY hospital executive owes to himself and his organization a knowledge of the latest developments in hospital apparatus. The convention of the American Hospital Association offers the opportunity to study and compare the newest improvements in hospital sterilizing equipment. Do not miss it.

The latest developments in Castle sterilizing efficiency will be displayed at the Castle exhibit. Whether you are a user of Castle equipment or not, a half hour spent at the Castle booth will profit you well—will be worth your while.

The apparatus exhibited will be the component elements of hospital sterilizing units rather than the units themselves. It will illustrate every phase of sterilization. From these basic parts careful selection may be made to meet the special sterilizing requirements of every institution, large or small. This is your opportunity.

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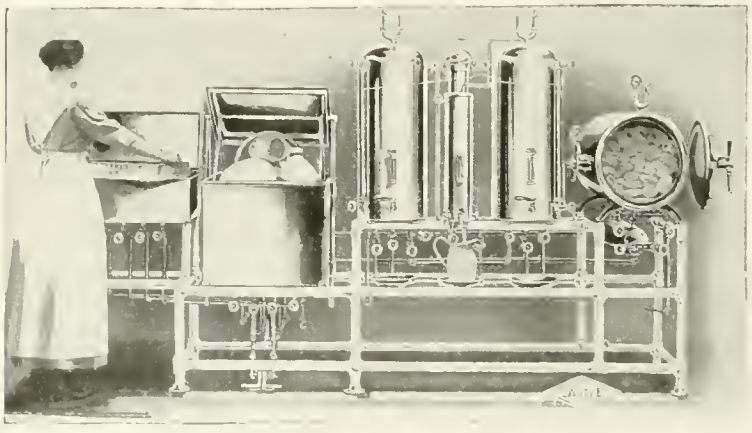

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CASTLE

ST. LOUIS HOSPITALS

ST. LOUIS CHILDREN'S HOSPITAL, ST. LOUIS

The St. Louis Children's Hospital has been in existence forty-two years, and was formerly located in the downtown section of St. Louis. It is non-sectarian in its benefactions and management, and is a teaching hospital having affiliation with Washington University on practically the same basis as that of Barnes Hospital. Its capacity is 150 beds, and of this number thirty-five are located in the contagious pavilion. In addition, the board of managers of the Children's Hospital maintains Ridge Farm, a convalescent branch at Valley Park, which has accommodations for fifty patients and is twenty miles from St. Louis, on a bluff overlooking the Meramec River.

BARNARD FREE SKIN AND CANCER HOSPITAL, ST. LOUIS

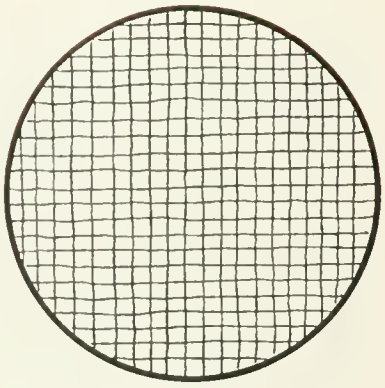
The Barnard Free Skin and Cancer Hospital, known originally as the St. Louis Skin and Cancer Hospital, was established in 1905, and grew out of a recognized need for such an institution both from a scientific and humanitarian point of view. The hospital has occupied a unique position in St. Louis as the only entirely free hospital, outside the city institutions. It is devoted to the treatment of malignant tumors and skin diseases. The enthusiasm of the board of directors in raising a $260,000 endowment fund and the gift of the new building by Mr. George D. Barnard permitted the extension of the work. Research work has been done since 1910 by scientists especially interested in this work. Complete x-ray equipment was established in 1917 and 110 milligrammes of radium was also purchased.

CITY SANITARIUM, ST. LOUIS

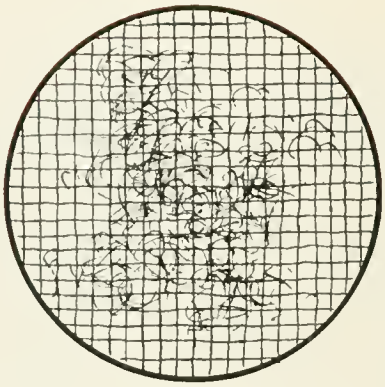
The City Sanitarium cares for nervous and mental cases and is financed by appropriations from municipal revenue. The population on April 1, 1921, was 2,415. There is a department of occupational therapy, and a social service department, admission through permit issued by the hospital commissioner or upon court order. The staff of medical officers is graded according to the term of service and efficiency. Its grounds consist of fifty-six acres, which are parked and gardened.

JEWISH HOSPITAL, ST. LOUIS

The Jewish Hospital is a good illustration of a modern small hospital which has endeavored to follow ideal lines. Every department of a general hospital is represented, except obstetrics, contagious diseases, and psychiatry. The accommodations include 110 beds, of which fifty-five are free, twenty part pay, and thirty-five in private rooms. The free beds are almost always occupied, in fact, it is the pride of the directors that no acceptable charity patient has ever been refused admission. A pathologist and a radiologist, with technicians for each, are employed, and an electrocardiographic equipment is provided. The training school, which was established twenty years ago, has granted diplomas to 165 graduates. Plans are about completed for a new building, costing $2,000,000, to be erected during the next year.



A screen placed over the drain valve of a Cascade still remained practically clean at the end of a week's time.



A screen placed over the drain valve of an ordinary washer became coated with lint in a very short time.

What the Drain Screens Show
—*about the Washing of Hospital Linens*

The amount of lint in the drain of a washer tells how much of the clothes have been worn away in washing.

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Clothes washed in the Cascade are conserved because there is complete open washing, practically without friction. The Cascade's exclusive and patented rib construction is the reason. There is complete penetration of the washing solution to the heart of the load in a minute's time. Washtime from breakdown to final rinse is reduced from 25 to 75 per cent.

Hospital superintendents who would make all garments and linens last longer will investigate this most modern of washing machines.

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ST. LOUIS HOSPITALS

CITY HOSPITAL, ST. LOUIS

The St. Louis City Hospital has one thousand beds, and is maintained entirely from municipal revenue, for the medical and surgical treatment of residents of the city, giving treatment to anyone in emergency. No charge is made or permitted for any service rendered. All branches of medicine and surgery are represented. A complete laboratory department, also maintained by the city, is located here.

A new four-story clinic building has just been completed, and provides a receiving room for the hospital, clinic rooms for the various specialties, detention wards, and prisoner wards.

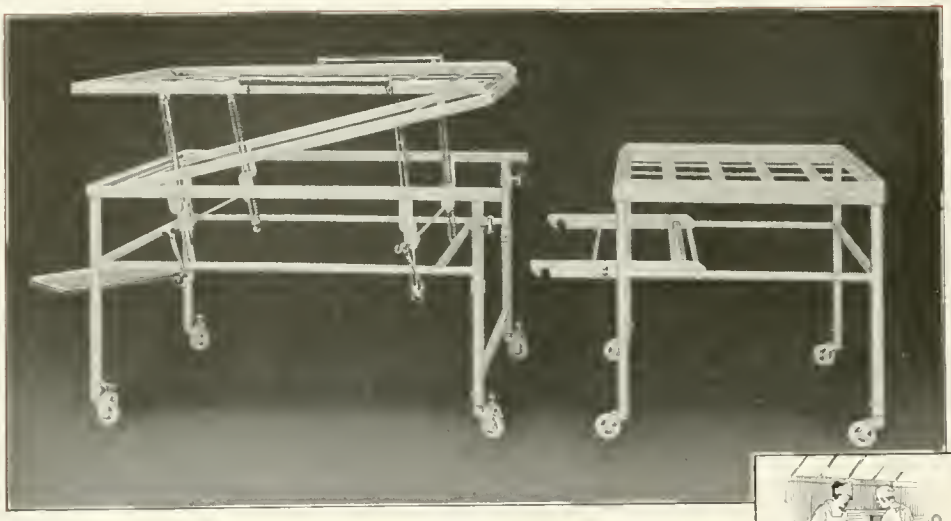
The St. Louis Training School for Nurses, established in 1883, is the oldest training school west of the Mississippi River, and is operated in conjunction with the hospital.

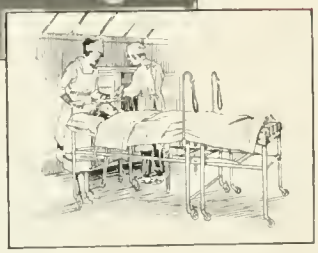
CITY ISOLATION HOSPITAL, ST. LOUIS

The City Isolation Hospital is used for the care of contagious diseases, except smallpox, tuberculosis, and leprosy. The institution is being constructed in units as the demand for increased facilities necessitates more room, depending on increased population and public health conditions. The present capacity is two hundred and fifty beds. The buildings are so constructed that no part is without sunlight at least part of the day, with four spacious solariums in each building which afford ample sunlight and fresh air for convalescent patients. The halls are of plate glass, affording the maximum light and at the same time giving the nursing staff complete control of all patients from any part of the building.

BARNES HOSPITAL, ST. LOUIS

Barnes Hospital is a hospital for sick and injured persons without distinction of creed. The funds left for its foundation by Robert A. Barnes were allowed to accumulate for twenty years after his death so that a hospital could be erected, adapted in every way to modern requirements. To carry out this ideal further, an affiliation was made with Washington University, so that it has all the benefits that accrue to a teaching hospital. Construction of the hospital was begun in 1912, and the building was dedicated in 1914. The capacity is 250 beds. In addition to the equipment usually found in hospitals, Barnes Hospital has an electrocardiograph, a metabolism ward, a hydro- and mechano-therapeutic department, a hospital library, and an occupational therapy department.





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ST. LOUIS AND INDIANAPOLIS HOSPITALS

MISSOURI BAPTIST SANITARIUM, ST. LOUIS

The Missouri Baptist Sanitarium was established by the Baptist denomination of Missouri in 1890 and began in a very small way. It now has a 300 bed capacity and is conducted as a general hospital with every facility for the best of service in every department. The training school for nurses offers a three years' course of training and is thorough in every department of work and instruction.

CITY HOSPITAL NO. 2, ST. LOUIS

City Hospital No. 2 is for negro patients. The negro physicians of the city of St. Louis felt that in order to serve the community better and render a more efficient service to their own people, it would be necessary for them to have better clinical opportunities, so they asked the city to either set aside a portion of the City Hospital or purchase another building where colored interns, nurses, and local physicians might be permitted to participate in the care of their own. In 1918 the city authorities, having been thoroughly convinced of the justice of their plea, purchased a six-story, fireproof hospital building, which they thoroughly renovated and remodeled.

THE PROTESTANT DEACONESS HOSPITAL, INDIANAPOLIS

The Protestant Deaconess Hospital was organized in 1895, and during the first five years of its existence patients were cared for by deaconesses. In 1899 a regular training school was organized with a three years' course. Members of this school were well represented in the recent war. One of their number, Miss Margaret Hamilton, was the first American nurse to die on duty at the front, and to be buried with military honors. The hospital has a woman's auxiliary to the Protestant Deaconess Society, whose chief interest is the care and comfort of the nurses and the proper maintenance of their residence.

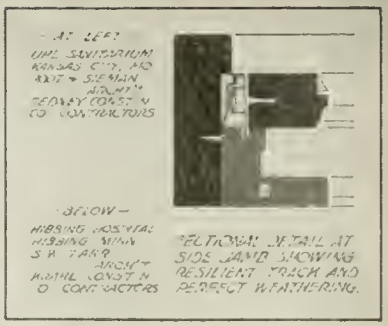
INDIANAPOLIS HOSPITALS

ST. VINCENT'S HOSPITAL, INDIANAPOLIS

St. Vincent's Hospital several years ago organized its visiting staff into a governing staff of thirty, and an associate staff of approximately 150 physicians. The policies and development of the hospital are now under the control of the governing staff, subject to the Sister Superior. The site of the present hospital, which was purchased from Fairbanks Park, links the hospital grounds with the park and boulevards system of the city.

SUNNYSIDE SANATORIUM, OAKLANDON, INDIANA

Sunnyside Sanatorium, an institution for the treatment of tuberculosis, is situated twelve miles northeast of Indianapolis, on a beautiful wooded track of thirty-eight acres. The hospital has a commanding view of the surrounding country, the elevation being advantageous in the treatment of the disease. Plans have been prepared for the building of additional units, to increase the capacity of the institution from eighty-five to 200 beds. An out-patient department is maintained in connection with the sanatorium, and clinics are held each week in Indianapolis for the examination of applicants for admission, and for discharged cases, all of whom are closely followed up, until a clinical cure has been attained.



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ST. LOUIS AND INDIANAPOLIS HOSPITALS

THE ROBERT W. LONG HOSPITAL, INDIANAPOLIS

The Robert W. Long Hospital, which was opened in 1914, is affiliated with Indiana University, whose trustees were charged with the establishment and administration of the institution, while the state was pledged to its maintenance. Since the hospital is intended primarily for persons unable to pay for treatment, 75 per cent of the patients cared for during 1920 were free patients. The training school for nurses is an integral part of Indiana University, whose students meet the entrance requirement of the University, and graduate with the University degree as graduate nurses. The social service department of the University conducts the case work and routine service of the hospital's social service, and also provides a state worker to follow the patients into their homes. This department carries on quite a extensive educational program, in teaching medical students, student nurses, and University students.

JOSEPH EASTMAN HOSPITAL, INDIANAPOLIS

The Joseph Eastman Hospital has, for a period of almost forty years, been engaged in the handling of major surgical conditions. At a time when the hospital treatment of disease was an innovation available to a fortunate minority only, this institution, through the efforts of its founder, Dr. Joseph Eastman, worked out many of the present-day axioms of institutional therapy. Dr. Eastman gave his life to the development of the hospital and did much toward the creation of the so-called modern surgical era.

CENTRAL INDIANA HOSPITAL FOR THE INSANE, INDIANAPOLIS

Department for women.

With other activities incidental to an institution such as the Central Indiana Hospital for the Insane, which has a capacity of 1,500 beds, Indiana University School of Medicine presents, in cooperation with the hospital, a course of clinical lectures given at the hospital, to its senior medical students, embracing psycho-pathology, psychiatry, neuropathology, and neurology. Exceptional opportunities are offered here for clinical study. Students who have taken this course number 783.

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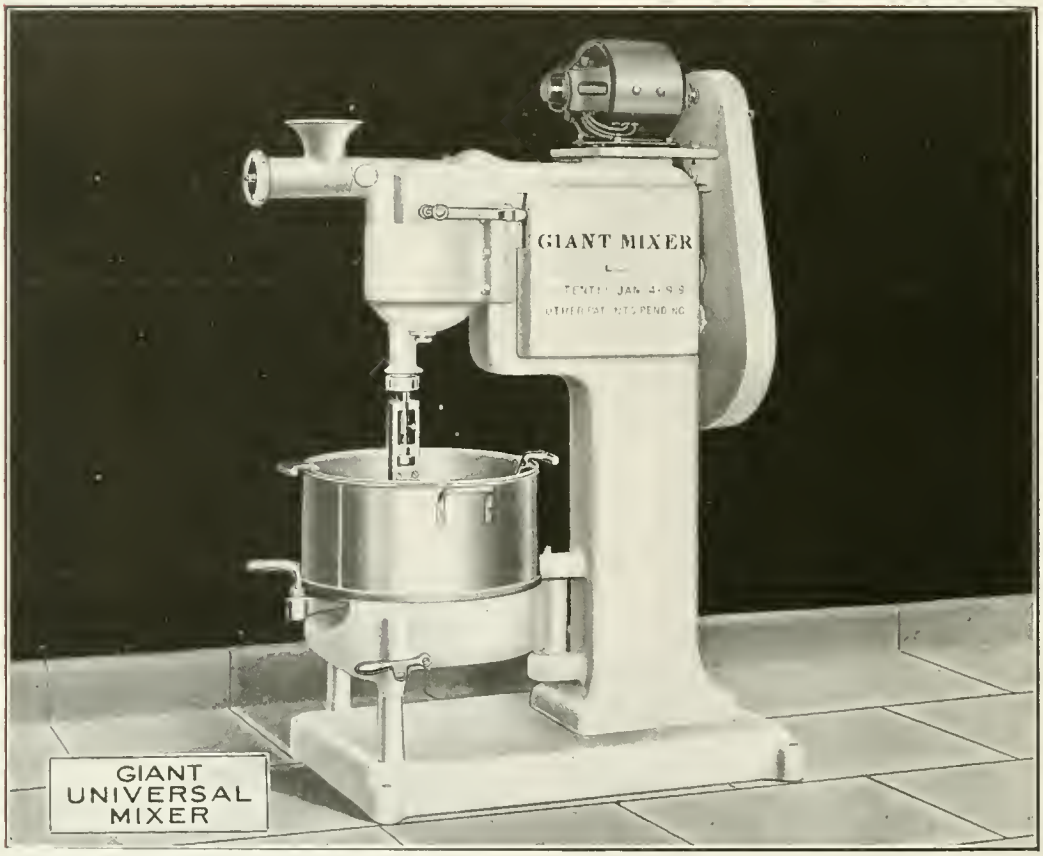

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INDIANAPOLIS AND LOUISVILLE HOSPITALS

INDIANAPOLIS CITY HOSPITAL

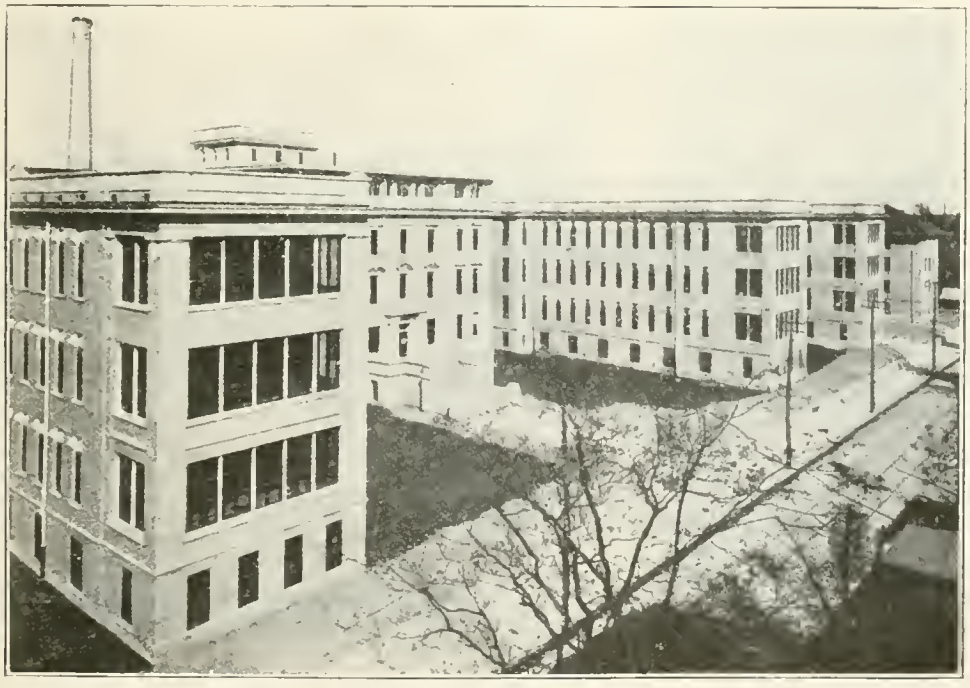
The Indianapolis City Hospital, which has a capacity of 450 beds, is general in type and is affiliated with the Indiana University School of Medicine as a clinical hospital. The training school, now one of the largest in the Middle West, maintains a postgraduate course, including surgery, obstetrics, pediatrics, contagious diseases, and diabetics. This hospital has an historical background, having been used for military purposes from 1861 to 1865, during which time 13,000 wounded soldiers were cared for.

THE METHODIST EPISCOPAL HOSPITAL, INDIANAPOLIS

The laboratories of the Methodist Episcopal Hospital are recognized for their accurate diagnostic work, and are under the supervision of experts. This hospital is the mother institution with branch hospitals in several other cities. The idea of a Methodist hospital was first seriously considered in 1899, at the time of the International Epworth League Convention at Indianapolis. The $4,000 which was left in the entertainment fund at the end of the convention, therefore, was used as the nucleus of a fund with which a Methodist hospital should be built.

THE NORTON MEMORIAL INFIRMARY, LOUISVILLE

Norton Memorial Infirmary, which was incorporated in 1886, is a general hospital of 110 beds, and the trustees are planning to build an addition in the near future. The various departments of the hospital are under expert supervision.



LOUISVILLE HOSPITALS

LOUISVILLE CITY HOSPITAL, KENTUCKY

Louisville City Hospital in 1914 opened a new million-dollar building on the site of the original building of the hospital, which was founded in 1822. The institution now accommodates 400 beds, and a large out-patient department is maintained. Besides the regular laboratories, special laboratories, such as medical research, basal metabolism, bacteriology, clinical pathology and others are maintained.

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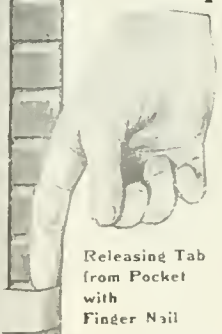

Releasing Tab from Pocket with Finger Nail

HOSPITAL EXPOSITION
AMERICAN ASSOCIATION
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West Baden, Ind.
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DER MFG. CO., SYRACUSE, N. Y.

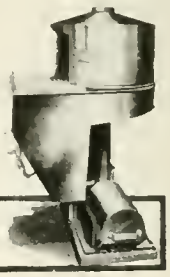
Have You a Weak Link in Your Institution?

FOR smoothly-operating efficiency in hospital administration, the big essential is individual strength of the individual factors of receiving, housing, feeding, nursing, accounting and other phases of caring for patients. A weak link anywhere in the chain immediately affects all the others, causes loss of time, increases expenses, decreases efficiency and multiplies annoyances.

Inadequate dish cleansing facilities comprise the weak link in many hospitals and institutions today. Thousands of dollars are spent unnecessarily for labor and for replacing broken china and glassware—except in institutions where the Autosan method has been adopted. Careful investigation by hospital executives and close comparison between dishwashing methods has always shown that in sanitation, and in lowered operating costs, there is no other method or appliance that can compare with the Autosan.

If 50 per cent less payroll in your dishwashing department and 60 per cent less breakage appeal to you, write today for illustrated folder XA-15 and the name of your nearest distributor.

COLT'S PATENT FIRE ARMS MFG. CO.
HARTFORD,
CONN., U. S. A.



AUTOSAN DISH AND SILVER CLEANING MACHINE

LOUISVILLE HOSPITALS

ST. JOSEPH'S INFIRMARY, LOUISVILLE

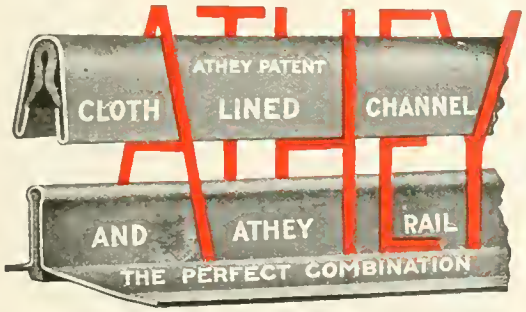
St. Josph's Infirmary is a general hospital under the direction of the Sisters of Charity of Nazareth, located in the heart of the business district of the city. It has lately purchased, however, a tract of land in the outskirts of the city, and expects to build a modern building there very shortly.

Athey

Cloth-lined Metal Weatherstrips
Perennial Window Shades

Exhibited in Booth 192

Athey Cloth-lined Metal Weatherstrips keep out cold air, dust, dirt, soot and noise. Permit easy operation of windows, yet the windows cannot rattle.



Insures definite economy in coal by keeping the warm air inside and the cold air out. Widely and successfully used by hospitals and hotels. Send for full particulars.

Athey Perennial Window Shades are made of heavy, ecru colored coutil cloth, so pressed and stitched as to maintain the accordion folds indefinitely.

Easily operated, lowered from the top or raised from the bottom. Shades are translucent but keep out glare and bright sunlight. Especially suited for hospital use. Send for illustrated circular.

ATHEY COMPANY

6035-45 W. 65th St.
CHICAGO, ILL.

Saving Footsteps!

—AND THE PFAUDLER GLASS LINED STEEL LAUNDRY CHUTE

View from Misericordia Hospital—looking directly into chute with door open. Laundry can be very conveniently deposited through these openings, which are located on all floors.

Tests of Superiority No. 2—One of a series on points which will inevitably put the Pfaudler Chute into every up-to-date hospital in the country.

See our exhibit at the Hospital Show at West Baden, Indiana, Sept. 12-16—Booth No. 27.

UPSTAIRS and downstairs, into elevators, down long corridors, this is the path of the tired nurse,—and many of these steps are unnecessarily taken. What you lose in this way and through the inefficiency of the laundry cart or other antiquated methods of laundry disposal, you definitely gain through the use of the Pfaudler Chute.

We refer you to any of the hospitals in which we have installed this chute, for their recommendation of it, a list of these being furnished to you at your request.

Tell your architect to specify this chute, and mail in the coupon below to obtain a price on the Glass Lined Chute as applied to your hospital.

The PFAUDLER CO.

The World's Largest Makers of Glass Lined Steel Equipment.

ROCHESTER, NEW YORK

NEW YORK 1802 World's Tower Building
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SAN FRANCISCO 206 Sharon Building

FOREIGN AGENCIES:
Enamelled Metal Products Corporation, Ltd., Imperial Bldgs., 56 Kingsway, London, England
Mauri Bros. & Thompson, 123-131 Castlereagh St., Sydney, Australia

— Clip and Mail This Coupon —

THE PFAUDLER CO.,
Rochester, N. Y.

.....1921.

Gentlemen: I would like quotations on your Glass Lined Chute.

Number of stories of my hospital is.....

Distance between floors is.....

Distance between vertical partitions of wall where chute is to be installed is.....

Send me your descriptive booklet.....

.....

.....

.....

LOUISVILLE HOSPITALS

ST. ANTHONY'S HOSPITAL, LOUISVILLE

St. Anthony's Hospital, conducted by the Sisters of St. Francis, has accommodations for 100 beds, and is planning an addition which will add seventy-five beds to its capacity. The hospital is noted for its beautiful grounds, which have gardens with a naturalistic grotto, and a tiny waterfall. Connected with the hospital is a chapel, which is considered the most beautiful in the state.

EXHIBITS
51 and 65
Convention of American Hospital Association

THORNER BROTHERS take pleasure in inviting you to visit their exhibit in Booths 51 and 65 of the Convention hall. A full line of Hospital Supplies of the highest grade will be on display.

Don't fail to see **Thorner Brothers Hospital Service Trays.** We will show a complete line of these trays fully equipped.

Our usual courteous attention to your wants will be given by those accustomed to calling on you at your institution.

THORNER BROTHERS

Manufacturers and Importers of Hospital and Surgical Supplies

386-390 Second Ave. New York City

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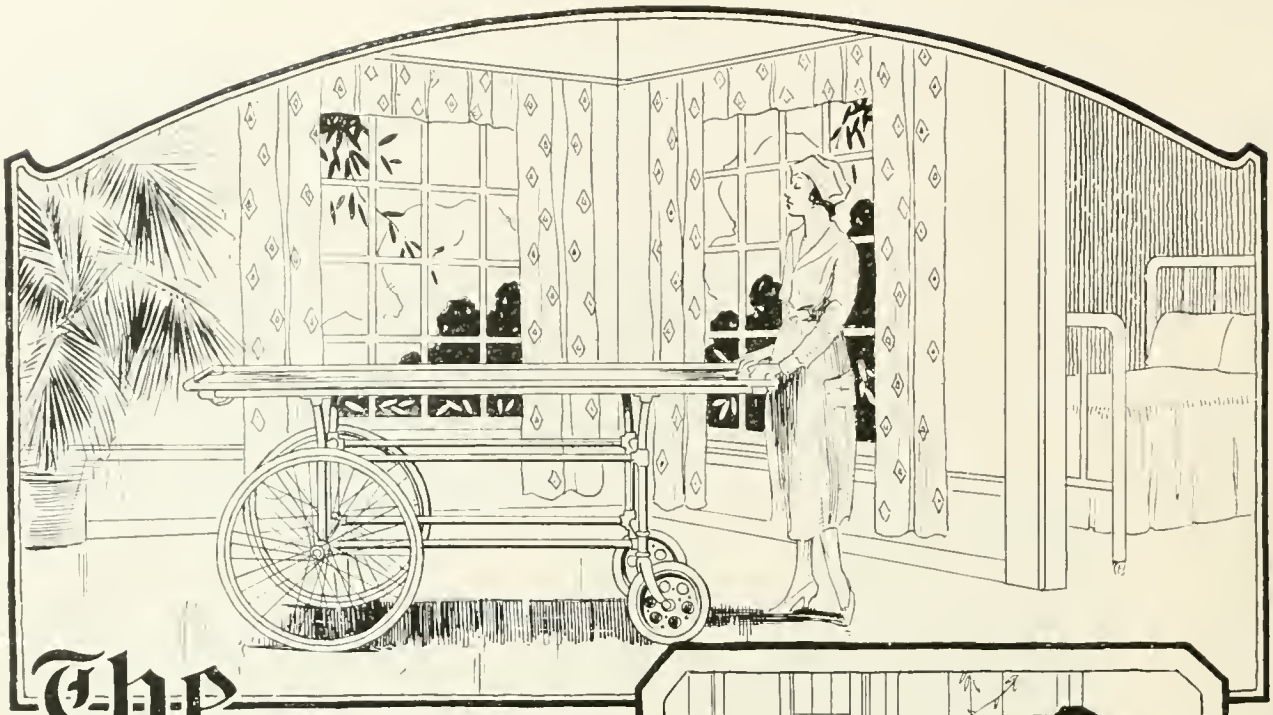
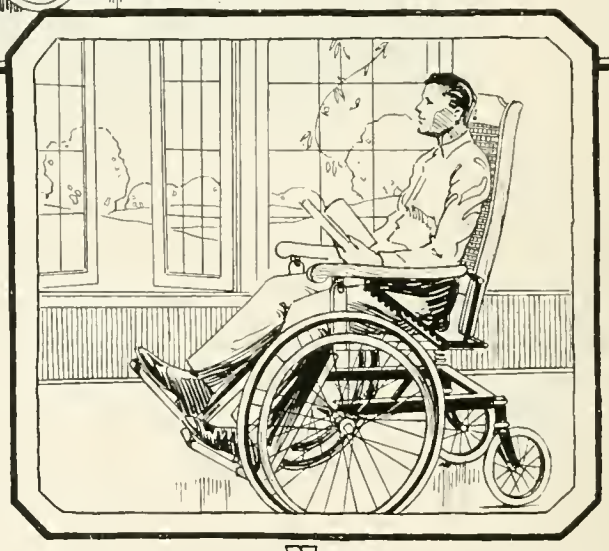


The Colson Line



You Will Find in Booths 118 and 125

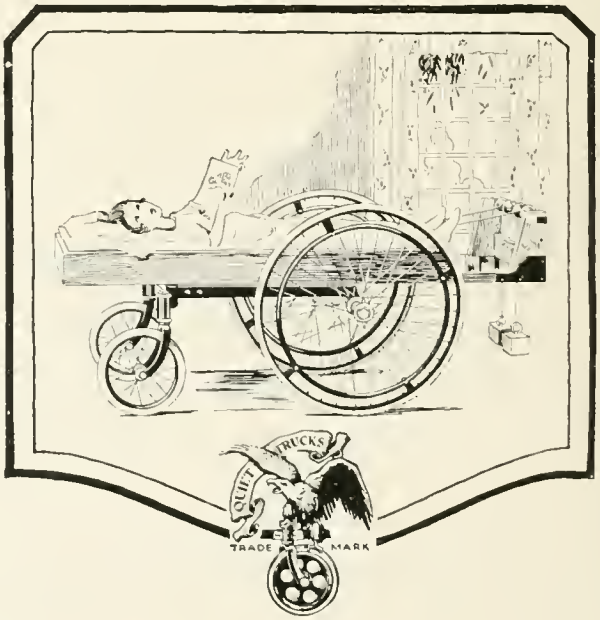
AT THE

West Baden Springs Convention

September 12-16-1921

There you will find a splendid showing of this complete line of

Hospital Wheel Equipment



The Colson Company

ELYRIA, OHIO

Branch Offices and Warehouses

NEW YORK 25 East 20th St. | CHICAGO 235 W. Randolph St. | LOS ANGELES 1317 Willow St.

LOUISVILLE HOSPITALS

CHILDREN'S FREE HOSPITAL, LOUISVILLE

The Children's Free Hospital with a capacity of seventy-five beds, is the only children's hospital in Louisville. Children up to twelve years of age are given medical and surgical care here, the hospital also supporting an out-patient department. All services are given free, although donations are accepted from patients whose circumstances permit. The grounds are well adapted for the pleasure of children convalescents, being furnished with swings and tents. The hospital has both a large and small operating room, and maintains its own x-ray plant.

Hospital Social Service

A monthly magazine published under the auspices of

HOSPITAL SOCIAL SERVICE ASSOCIATION OF NEW YORK CITY, INC.

Editorial Office

19 E. 72nd St. New York City

THE BASIS OF HOSPITAL SOCIAL SERVICE is the more adequate medical care of the patient. Treatment once begun in the hospital's ward or out-patient department must be carried to completion through education and follow-up of the doctors orders. The over worked physician of the present has not the opportunity to devote the necessary time to the infinite details which modern therapeutics demand. So the Hospital Social Service Department has been developed to assist the physician.

THIS JOURNAL REPRESENTS THE GROWTH OF HOSPITAL SOCIAL SERVICE in this country and abroad by original articles by doctors, superintendents and social workers in hospitals. Special attention is paid to nutrition, psychiatric, cardiac and handicapped medical social service.

Subscription Price: Domestic, $3.00. Canada, $3.50. Foreign, $4.00

Advertising rates on application

THE idea of a "service" department qualified to give expert advice in cleaning science was the inception of the thought, the development of which has been a long recognized principle with The J. B. Ford Company, believing all worth while business should be based on superior service.

Coincident with the rapid growth of the use of

Wyandotte Products

this service department extended its usefulness until today we are able to offer in conjunction with the distinctive and unusual character of the Wyandotte Products, a service which will assist you to place your cleaning operations in all departments upon a basis of efficiency and economy and you will be surprised at the saving in time, labor and cost which results.

The personnel of our service department is composed of men specially trained in institutional cleaning work, and as they travel through all parts of the country visiting and consulting with institutions of all sizes, they are able to add to their own scientific and practical knowledge the experience of others thus broadening their usefulness to those who unlike themselves have had neither the time nor the opportunity for such training.

This "service" is entirely free to users of Wyandotte Products.

LOUISVILLE HOSPITALS

SAINTS MARY AND ELIZABETH HOSPITAL, LOUISVILLE

Saints Mary and Elizabeth Hospital, established over fifty years ago, under the direction of the Sisters of Charity of Nazareth, is a general hospital of 150 beds. One of its special features is an emergency room, where the injured employees of several railroads and industrial plants are treated.

Now Ready
The NEW STERLING CATALOG

Every day we get new information on the remarkable efficiency of Sterling Machines used daily in Hospitals, Hotels, Restaurants, Cafeterias, Institutions, Clubs, etc.

You are interested in how Sterling Equipment may serve you in this same efficient way. This new Sterling catalog explains how.

It describes

All sizes and styles of peelers for hand power, belt drive and complete motor-driven outfits, also the hand masher with its puree and mayonnaise mixer attachments and the large, power-driven masher.

Eight different styles of meat, fruit and vegetable slicers, cuber and French Fry cutter. Large size No. 95 meat slicer, fruit and lard presses in three popular sizes.

Excellently illustrated, with concise, readable description it contains the exact information you will appreciate.

Your copy is ready—awaits the word from you to mail it. No obligation.

JOSIAH ANSTICE & CO., INC. ROCHESTER, N. Y.

SUCCESSORS TO N. R. STREETER & CO.

At the Convention—In Booth No. 70

Will Ross

WHOLESALE HOSPITAL SUPPLIES

432 Broadway **MILWAUKEE** 432 Broadway

Booth No. 70

Make a point of seeing the new suggestions in tray service that we will be showing at the convention. Let us tell you too, something of what we are trying to do in standardizing the business of hospital supply. You will not, here, be over-urged to buy.

Booth No. 70

Paper Supplies
Surgical Cottons
Hospital Garments
Rubber Sundries
Thermometers, Syringes and Sutures

Tray Ware
Enamelwares
Hospital Furniture
Tuberculosis Supplies
Hospital Notions

"THE BUSINESS THAT TRULY SERVES KNOWS NEITHER LIMITS NOR BOUNDARIES"

WELCOME

TO

BOOTHS 63-64

Everything in Hospital Sundries

SOUTHERN SELLING AGENTS
HYGIENIC FIBRE CO.
ABSORBENT COTTON
GAUZE—BANDAGES
SANITARY NAPKINS
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RUBBER GOODS
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HOSPITAL GLASSWARE
INVALID CHAIRS
HOSPITAL FURNITURE
WHITE ENAMEL WARE

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BRAMHALL-DEAN STERILIZERS

SPECIAL SALE
MALLINCKRODT ETHER

MASSILLON RUBBER GLOVES

SURGICAL SELLING CO.

Wholesale Hospital Supplies

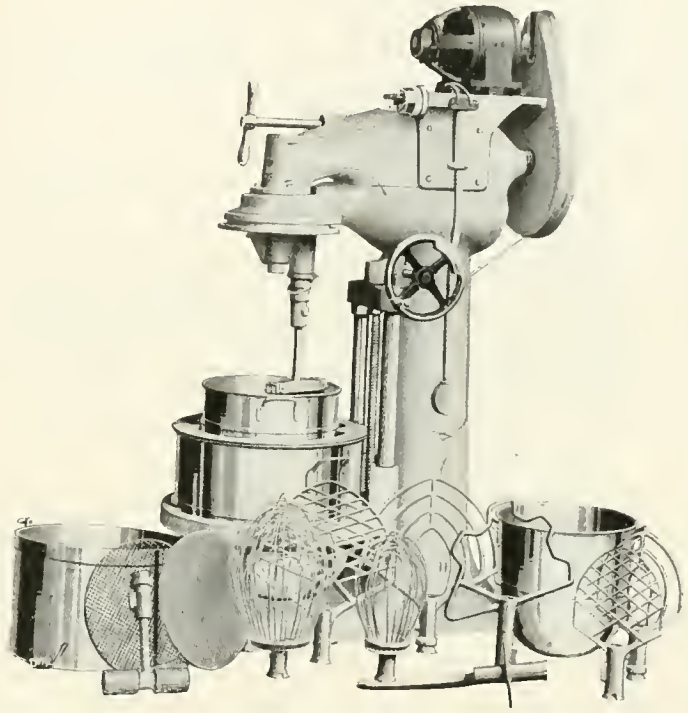
53 WALTON ST. ATLANTA, GA.

The Best Help in the Kitchen

A Read Three Speed Mixer

Ask a few of the users

Bryce Hospital, Tuscaloosa, Ala
City & County Hospital, San Francisco, Cal.
St. Joseph's Hospital, San Francisco, Cal.
St. Francis Hospital, Hartford, Conn.
U. S. Naval Hospital, New London, Conn.
Providence Hospital, Washington, D. C.
Cook County Hospital, Chicago, Ill.
Michael Reese Hospital, Chicago, Ill.
U. S. Public Health Hospital, Camp Lawrence, Chicago, Ill
Johns Hopkins Hospital, Baltimore, Md.
Harper Hospital, Detroit, Mich.
Bethesda Hospital, St. Paul, Minn.
Newark City Hospital, Newark, N. J
U. S. Naval Hospital, Brooklyn, N. Y
King's Park State Hospital, King's Park, L. I., N. Y.
Bellevue Hospital, New York City
Montefiore Home, Hospital & Sanitarium, New York City
Presbyterian Hospital, New York City
St. Vincent's Hospital, New York City
Rochester General Hospital, Rochester, N. Y.
Crouse-Irving Hospital, Syracuse, N. Y.
St. Luke's Hospital, Bethlehem, Pa.
Friends' Hospital, Frankford, Pa.
Lankenau Hospital, Philadelphia, Pa.
Misericordia Hospital, Philadelphia, Pa.
Pennsylvania Hospital for Insane, Philadelphia, Pa.
St. Agnes Hospital, Philadelphia, Pa.
St. Vincent's Hospital, Philadelphia, Pa.
Luther Hospital, Watertown, S. Dak.
Thomas Dee Hospital, Ogden, Utah.
U. S. Naval Hospital, Hampton Roads, Va.
Swedish Hospital, Seattle, Wash.
Columbia Hospital, Milwaukee, Wis.



Read 3 speed Kitchen Machine
(Patented)

The Read Three Speed Mixer is the best. All good Hotels and Restaurants use it. A Hospital Kitchen is more important; so why not equip it with the best.

Come in and operate one in booths 52 and 53
West Baden Show

YB
Page 711

THE READ MACHINERY COMPANY, YORK, PA.

Branch Sales Offices

New York, Chicago, Boston, Philadelphia, Pittsburgh, Cleveland, Indianapolis, Minneapolis, St. Louis, Kansas City, San Francisco, London and Paris.

The American Dollar and "AMERICAN" Sterilizers—

WITH all eyes centered upon Price, the purchasing power of the American dollar has never been so taxed as it is today.

We sense that *you* are not immune to the price appeal in the purchase of your equipment. You are seeking the very most your money will buy—and rightly so. It is, therefore, a source of keen satisfaction to us to know and *be able to prove* that

"AMERICAN"
Sterilizers & Disinfectors

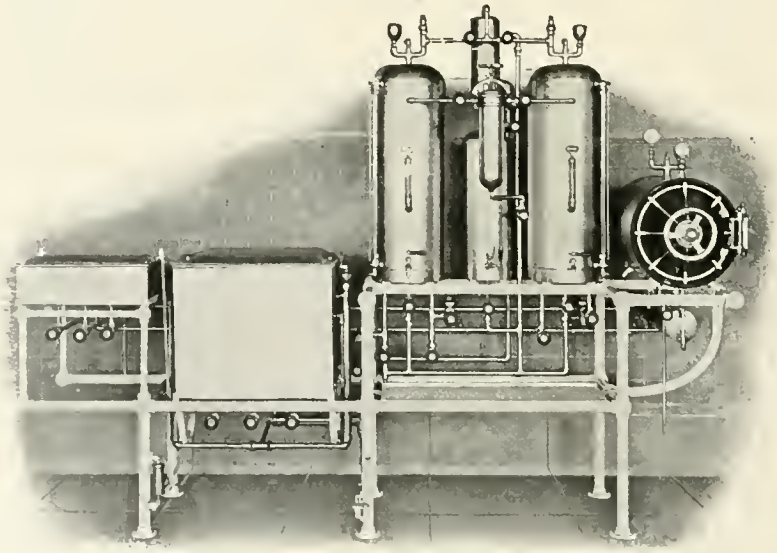
at present prices represent the *greatest* Sterilizer and Disinfector value obtainable. Notwithstanding the fact that they cost more to manufacture, due to the use of finer materials, more searching tests, more scientific and precise shop and machine work, more exacting inspection, *and are consequently worth far more to the owner*, they are sold today for *less* per unit of value than any similar apparatus made. Greater skill, greater specialization, greater achievement do not make the "AMERICAN" cost more—*they do make it worth more.*

And the purchase price, low as it is, is greatly lessened in the years of uninterrupted service because of low maintenance and operating costs. Your dollar has been creditably spent when it goes for "AMERICAN" apparatus.

Descriptive bulletins, engineering data and specialists' counsel are free for the asking

AMERICAN STERILIZER COMPANY
ERIE, PA.

New York Office: Fifth Ave. Bldg., 200 Fifth Ave.



"AMERICAN" Steam heated combination outfit, comprising water (with still), dressing, instrument and utensil sterilizers.

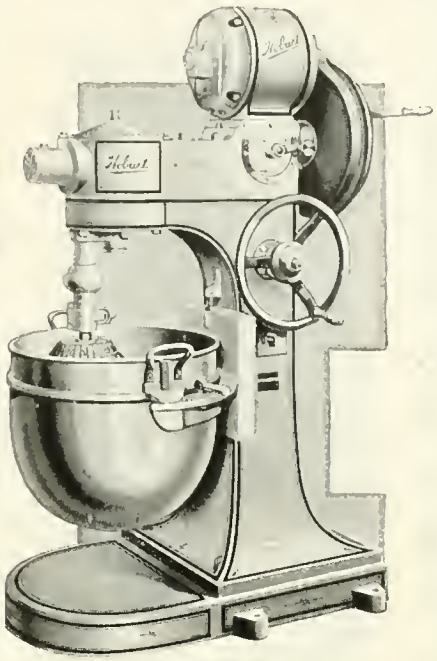
Convention Headquarters SPACE 1 2 3

In charge of our Pres. dent, Mr. J. E. Hall, who hopes to meet there his many friends, and who will cordially welcome anyone interested in the subject of sterilization.

Convention Headquarters SPACE 1 2 3

Showing a varied line of "AMERICAN" Sterilizers, including Dressing, Water, Utensil, Instrument, Portable, Blanket Warmer, etc. If you have a sterilizer or disinfector need, let us discuss it with you.

Make the Hard Work Easy—and Less Expensive!



THERE'S no really hard work in a kitchen where a Hobart Mixer is used. Such ordinarily tedious tasks as mixing, beating, whipping, chopping, grating, slicing, crumbing, straining and grinding are done quickly, easily —and you'll be surprised with how much less expense.

The Hobart Mixer makes it a simple matter to handle the rush hours—and foods are better prepared, too! Not only will it add to the efficiency of your kitchen, but will soon pay for itself in actual savings. Every particle of material is "worked up" — giving you more product for the same cost.

There is a Hobart Mixer in the size you need, whether it be a 10, 20, 30 or 80 quart capacity. Let us send you complete information and prices. Hobarts are sold on easy terms, if you wish.

See Our Exhibit Booth No. 24 at American Hospital Exposition

The Hobart Manufacturing Company
105 Penn Avenue Troy, Ohio

The Hobart Mixers
ELECTRIC WORKERS
COFFEE MILLS and MEAT CHOPPERS

A Few Hospitals Using Hobarts

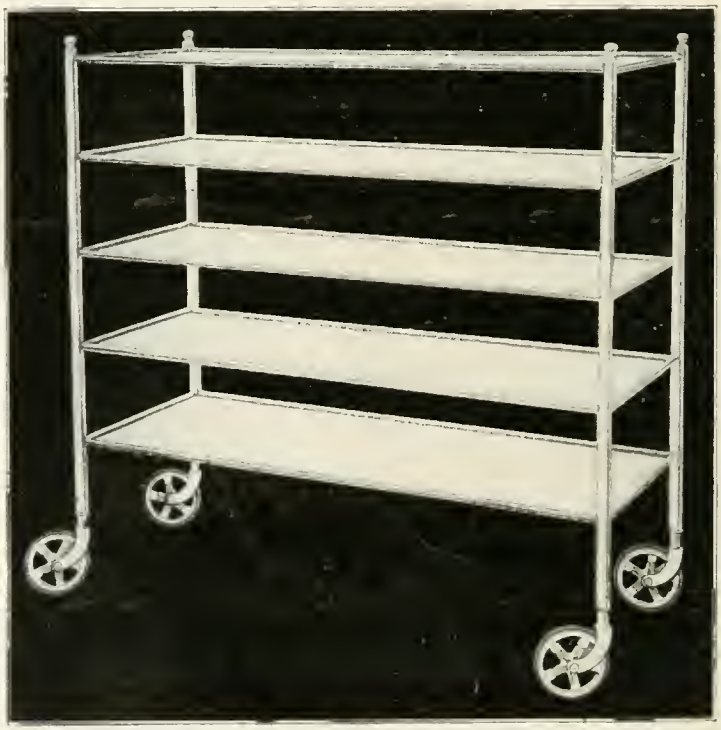
Homeopathic Hospital, Buffalo, N. Y.
Good Samaritan Hospital, Zanesville, Ohio
Moody Hospital Dothan, Ala.
Palmerton Hospital for Insane Palmerton, Pa.
State Hospital for Insane Norristown, Pa.
The Abbott Hospital Minneapolis, Minn.
Hot Lake Sanatorium Hot Lake, Ore.
Mountain Sanatorium, Hamilton, Ont.
St. Francis Hospital Colorado Springs, Colo.
Westminster Military Hospital London, Ont., Canada
St. Anthony's Hospital St. Louis, Mo.
The Palmerton Hospital New York City, N. Y.
U. S. Military Hospital Des Moines, Iowa
A. N. Brady Maternity Hospital Albany, N. Y.
Oil City Hospital Oil City, Pa.

Instrument and dressing cabinets in large variety will be exhibited. The special **utility cabinet** listed above is one of our new and popular numbers, especially desirable for ward and pavillion use.

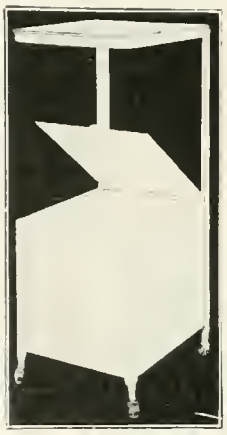
The Completeness

The completeness of our exhibit at the convention of the American Hospital Association fittingly reflects the extent of our line of hospital equipment and supplies. Recognized as the largest manufacturers and jobbers of hospital and surgical equipment, it was but natural that one of the largest, if not the largest space at the exposition would be required for our display.

Visiting hospital executives will find a wide assortment of supplies needed daily in their institution. Their high quality can be verified by comparison with other exhibits; the price that is asked indicates how quantity production enables us to save you money.



This splendid tray **carrier** will greatly increase the efficiency of your food service. Other wheeled carriages and stretchers will be exhibited. All are designed so as to combine the greatest possible durability and convenience.



One of the features of our exhibit will be a new **combination bedside table and bed tray**, combining in one piece of furniture all conveniences for which two separate tables are ordinarily required. It has removable tray and is so constructed that the storage compartment will slide under the ordinary bed fabric.

FRANK S. BETZ CO.

HAMMOND, IND.

Chicago
30 E. Randolph St.

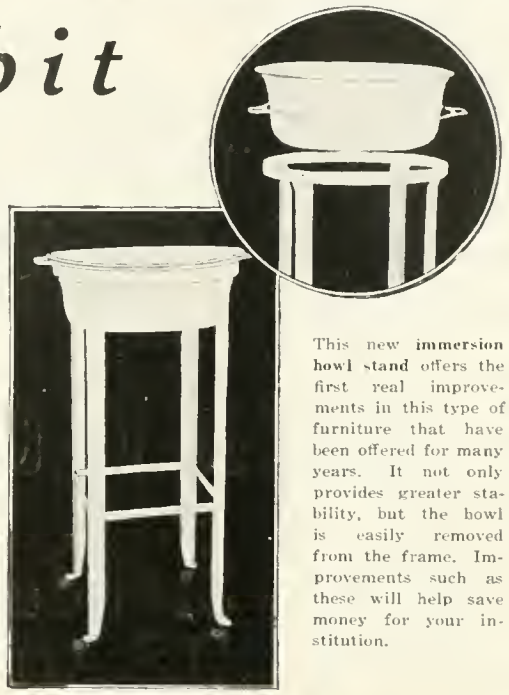
New York
6-8 W. 48th St.

SPACES
151
152
165
178

# of Our Exhibit

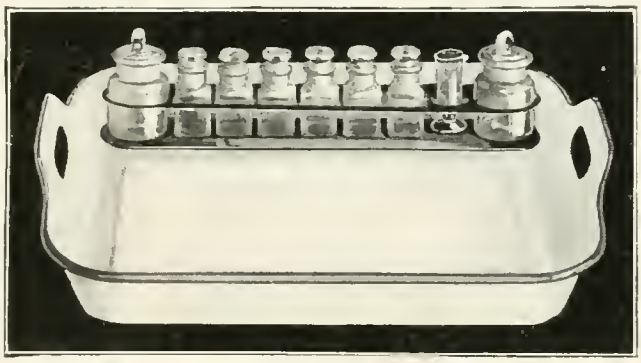
Special emphasis will be given in the exhibit to new pieces of equipment that will increase the efficiency of your hospital; in fact more new designs in hospital furniture are offered than were before exhibited at a convention. These new pieces will appeal, not only to the new hospital, but to established institutions that are anxious to introduce economies, yet maintain the high quality of service offered.

Every facility will be offered visitors to confer with our factory experts in regard to any phase of technical equipment and routine supplies.



This new **immersion bowl stand** offers the first real improvements in this type of furniture that have been offered for many years. It not only provides greater stability, but the bowl is easily removed from the frame. Improvements such as these will help save money for your institution.

The **nurses' desk and chart cabinet** shown above has been found the most convenient type for general hospital use. Not only are the chart files out of the way of the nurse using the desk, but they can be removed or replaced without disturbing her. One of many styles that will be shown at the convention.



The up-to-date hospital now provides **tray sets** for nearly every clinical purpose. A full assortment of these special tray outfits, completely equipped, will be shown at the convention, and specially equipped trays can be readily designed. Little conveniences such as these save the time of your nurses and interns.

A complete assortment of surgeons' gloves and other rubber goods as well as enamelware and instruments and supplies of every description will be displayed.

SPACES
151
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FRANK S. BETZ CO.

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Chicago
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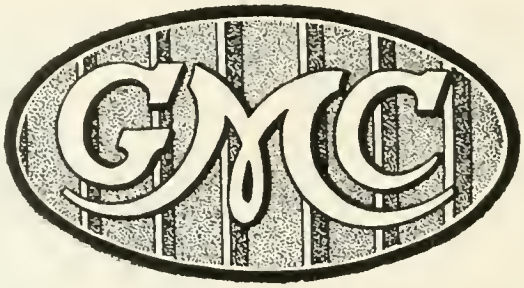


Ambulance

Standard of the U.S. Army Medical Corps. Thousands were in service in France during the World War.

Visit Booth 173 and arrange to inspect the fully equipped ambulance displayed at hotel entrance.

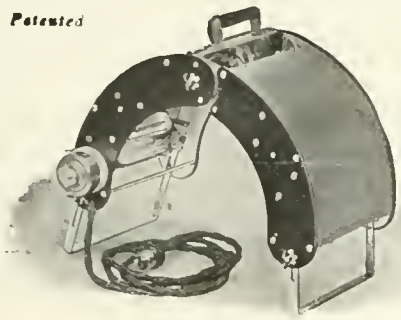
This ambulance is shown unpainted, so that its construction may be thoroughly studied.

GENERAL MOTORS TRUCK COMPANY

PONTIAC, MICHIGAN

A Unit of the GENERAL MOTORS CORPORATION

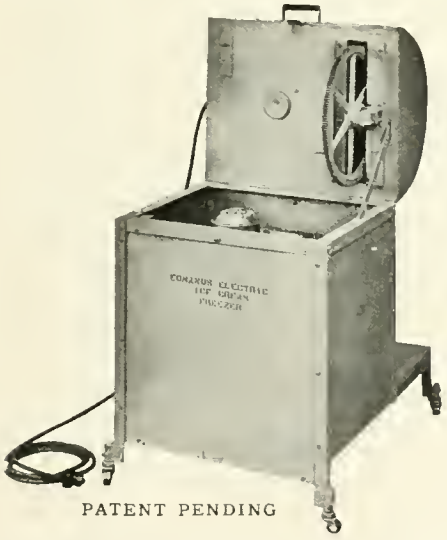
Edmands Electric Bakers



EDMANDS ELECTRIC BAKERS take the place of any number of special Bakers for special treatments as they are adjustable to the contour of any part of the body.

The increasing demand for the large sizes indicates that they are rapidly coming into use in treating the whole or part of the body.

Have you tried the Edmands Baker Lamps?



PATENT PENDING

EDMANDS ELECTRIC ICE CREAM FREEZER

In saying that it is one of the most practical Electric Ice Cream Freezers for household or hospital use, I am quoting the expert opinion of several Electrical Appliance dealers.

In saying that it is one of the most practical Electrical Ice Cream Freezers for household or hospital use, I am quoting the expert opinion of several Electrical Appliance dealers.

Manufactured by

WALTER S. EDMANDS

25 Pearl St., Boston

Booth 63

American Hospital Association Convention

West Baden Springs, Indiana

SEPT. 12TH TO 16TH

will contain a practical and instructive exhibit of

HYGIENIC-MADE

Absorbent Cotton and Gauze Products.

Tests Prove the Better Quality of

Hygienic-Made

Absorbent Cotton and Gauze Products

IT PAYS to be particular in purchasing these supplies, and the more exacting you are the more you will appreciate the better quality of Hygienic-Made Products.

Made in a modern laboratory, located in the country, where sunlight, fresh air, sanitation, extreme care and superior processes enable us to put out a better, purer and whiter product. These products are washed repeatedly and bleached thoroughly in unlimited quantities of clean, fresh, spring water taken directly from the flowing stream. They meet every hospital requirement and are sold on a "Best by Test" basis that guarantees quality.

To acquaint Hospital Superintendents and other visitors with these better quality products, we are exhibiting them at the American Hospital Association Convention and cordially invite all visitors to see Booth No. 63.

HYGIENIC FIBRE COMPANY

Manufacturers of Absorbent Cotton and Gauze Products

200 Broadway New York City

Mills at Versailles, Conn.

A *successful* Rolling Screen

Rolup SCREEN

In the fall—

You needn't take it down and store it in the cellar or attic to rust and gather dust. Just "let it up" to the window top as you would a shade—out of sight for the winter.

In the spring—

No drudgery of putting it back, no repainting, no repairing. Just draw it down—as you do your shade—clean, fresh and instantly ready for summer duty.

A ROLUP in every window

The spring roller is concealed in an inconspicuous metal case at the top of the window. Patented metal grips fastened to the edges of the screen along its entire length hold it tight to the woodwork, gliding in narrow metal slots attached like weather strips to the sides of the window frame.

Rolups are always smooth and taut in motion or at rest. They completely cover the entire window, allowing perfect ventilation without admitting flies, mosquitoes or other insects. Rolling up and down smoothly, they permit quick, easy adjustment of awnings, blinds and casements.

ROLUPS cannot rust

Made of the famous Monel Metal (a mixture of copper and nickel) the Rolup never rusts or corrodes in town, country, or by the sea.

The Rolup Screen is a necessity in every hospital. It costs no more than regular copper screens. Write for literature. Estimates furnished.

BOOTH 131

ROLUP SCREEN COMPANY
17 BATTERY PLACE
NEW YORK

knowing where

Exact knowledge on many subjects is obviously difficult.

Knowing where to find the desired information is practical knowledge.

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In this one volume is contained all essential buying information for hospital executives. From the alphabetical index of products, through the classified directory of dealers and manufacturers, to the condensed catalogs of the leading firms, the desired information is logically and conveniently available.

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The Modern Hospital Publishing Co.
CHICAGO

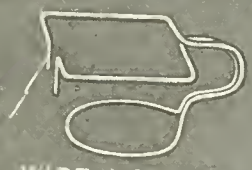
SIMPLEX SANITARY

NOTE
THE AUTOMATICALLY CLOSING COVER,
THE GRADUATION MARKS,
THE ABSENCE OF UNSANITARY INSIDE FLANGES,
THE ABSENCE OF UNSANITARY HINGES ON THE HOLDERS.

SHOWS CUP IN WIRE HOLDER WITH COVER RAISED

TRADE SIMPLEX SANITARY MARK

NICKEL-PLATED METAL HOLDER
Stamped from One Piece of Metal



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FLAT OR KNOCKED-DOWN CUP WITH COVER ATTACHED.
THE "SIMPLEX SANITARY" SPUTUM CUP IS SOLD IN EITHER THE FOLDED SHAPE OR THE KNOCKED-DOWN SHAPE.

THE IDEAL
PAPER SPUTUM CUP
FOR USE IN EITHER HOSPITAL OR SANITARIUM

IMPROVED FEATURES

1. Each Cup has a cardboard cover attached with a paper hinge, and both Cup and Cover are burned after being in use a day.
2. The Cover is quickly and easily raised and closes automatically.
3. The wide opening and absence of flanges allow free entrance of sputum. With the ordinary tin holder, which has a hinged cover, the sputum very often lodges in the crevices of the hinge, thus making the Holder unsightly, unsanitary, and not only very objectionable, but very difficult to clean.
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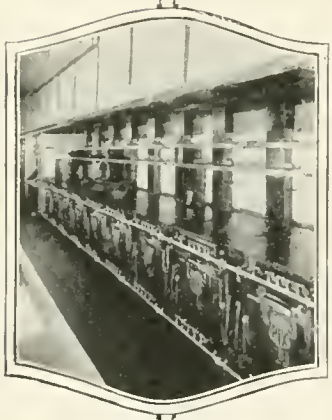

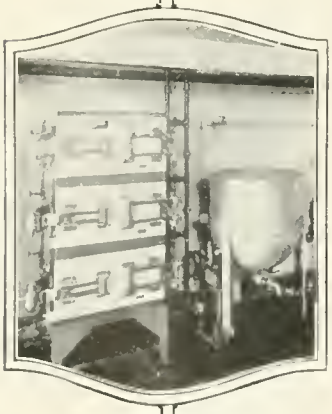

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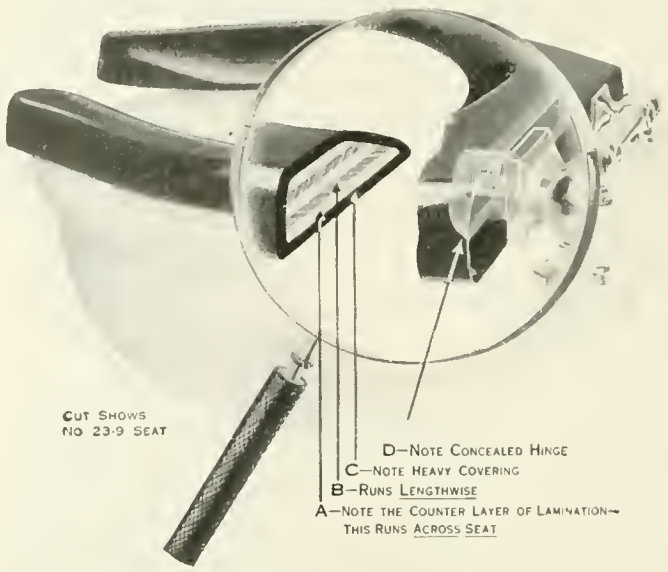
CUT SHOWS NO 23-9 SEAT
D—NOTE CONCEALED HINGE
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Cracked, split, deteriorated surfaces of toilet seats
means liability of contagion and
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To refinish only means surfacing
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If you cannot secure locally,
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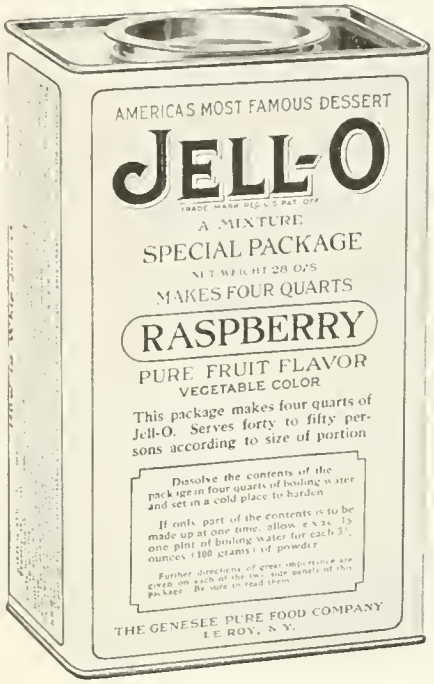
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JELL-O
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MAKES FOUR QUARTS
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PURE FRUIT FLAVOR
VEGETABLE COLOR
This package makes four quarts of Jell-O. Serves forty to fifty persons according to size of portion
Dissolve the contents of the package in four quarts of boiling water and set in a cold place to harden
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Our institutional size package represents the same standard of quality that has made our product such a favorite for so many years.

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FAR-REACHING RESULTS

A new hospital recently lost a staunch friend who had contributed generously to the building fund. This contributor, herself a heart case, would not forgive the superintendent and trustees for permitting the hospitals to be so designed that a flight of some twenty steps had to be climbed by the visitor or patient who made use of the main entrance.

HOW ARE YOUR VISITORS TREATED?

Imagine the dismay of a visiting superintendent when on asking to be shown over a fine hospital, apparently the youngest and greenest probationer in the place was sent out to do the honors. And imagine the dismay of the probationer! The visiting superintendent apologized to the probationer, but told her that she would not care to go through with her as she feared that she did not know very much about the hospital herself. The probationer had sufficient presence of mind to ask the visitor to wait a few moments. The superintendent was notified of the dilemma and hurrying out from her private office showed the visitor around the hospital herself. Surely a definite impression of an institution is created by the manner in which one is received when visiting there. Take care that your hospital leaves a cordial and hospitable impression in the minds of its visitors.

CONCENTRATING THE BUYING POWER

The board of a certain hospital has a women's aid association that does all the buying, with the exception of food and surgical goods. The association is divided into committees, one for each kind of article bought. It is the superintendent's duty to remember the chairman of each committee, never on any account getting them mixed, and notify them when supplies are needed. In this case the superintendent states that much money could have been saved the hospital if the buying power had been concentrated in his hands. It is obviously impossible for a decentralized system, such as this one, to be run in an efficient, economical way.

Another hospital board does not allow its superintendent to buy supplies or even give orders to the hospital carpenter for necessary repairs.

If a few Yale locks are needed, a committee is appointed to go and buy the locks and see to having them put on. The superintendent is likewise not allowed to decide which private rooms should be cleaned first—ah, no! That is the duty of the house committee.

Some superintendents are so involved in red tape that if supplies are needed in an emergency they cannot be bought without a requisition slip signed by the chairman of the supply committee. Such conditions are impossible, and measures should be taken to remedy them wherever they exist.

SOME PRACTICAL SUGGESTIONS IN HOSPITAL PUBLICITY

At a recent meeting of the National Methodist Hospital and Home Association held in Chicago, Ralph Welles Keeler, counsellor in publicity to the Board of Hospitals and Homes of the Methodist Episcopal Church, made some definite suggestions on hospital publicity. He said: "Train some one person to do your publicity work and give him an opportunity to do it. Always use the full corporate name of your institution. Thousands of dollars left in wills have failed to reach the institutions for which they were intended because of the testator's ignorance at this point. Visit automobile, electric and food shows and the like in order to get up-to-date printed matter for suggestions. Study the advertising in the magazines and in your local papers. Make every patient a booster. Make definite propositions as to what definite sum of money will do. Remember that cheap printing is expensive. Keep in mind the fact that leaflets are of no use unless in the hands of the people for whom prepared. Study distribution. Be definite and concrete in all your publicity. Never hesitate to let the general public know the purpose of your institution, how it is run, what it costs to run it, how it is supported, etc. Stories of actual experience have the strongest appeal. A deficiency is more apt to secure sympathy and assistance than a surplus; provided always that it is made clear that the deficiency is not the result of bad management but of attempting to meet an increasing demand for improved service. Physicians enjoy small blotters that really blot, and small desk calendars. A postal card with an attractive picture, generally not a building, is useful. An attractive letter-head which is carefully thought out and well printed is a constant medium of publicity.'"

DOES SILENCE REIGN?

Do noisy food and ice conveyors, and squeaking wheelchairs go rollicking along the corridors of your hospital, mocking the silence and quiet signs that they momentarily pass? If so, why not organize a society for the prevention of needless noise, similar to the one now in existence at the Mount Sinai Hospital, Cleveland, Ohio, and commented on in an editorial in our July issue, under the caption "Preventing Needless Noise." A letter to the director of that hospital, Mr. Frank E. Chapman, will bring the details you need for its organization.

HOSPITALS AND THE EIGHT HOUR DAY

There have been many inconveniences suffered by hospitals in France, from the strict application of the law of April 2, 1919, establishing an eight hour day throughout France. In view of the bitter complaints by physicians and surgeons, the minister of social hygiene and provision has called the attention of the prefects to the hardships of the hospitals. The hospitals have suffered not only from lack of personnel necessitated by this change in schedule, but also from lack of funds to pay an increased personnel. The law, however, provides for certain exemptions, some permanent and some temporary. The permanent exemptions take cognizance of the classes of personnel performing preparatory or supplementary work that must be done outside of the working hours of the establishment in question. The temporary exemptions are in the case of large business houses which occasionally must meet sudden emergencies involving a large volume of work, necessities of a national character, and accidents and disasters. The law has also been regulated to trades that are exposed to shut-downs and inclemencies of the weather, as, for example, building, or trades which are intermittent in character.

These exemptions may also apply to hospitals. The minister has therefore asked the hospitals to furnish a detailed statement in regard to the regimen that should be provided for their various classes of personnel.

REPRESENTATIVES HONORED

The British gave a dinner on June 13, at the Carlton Hotel, London, during the Colonial Health Conference, in honor of the representatives of the Rockefeller Foundation, George E. Vincent, Wickliffe Rose, and Vincent G. Heiser. The honorable Winston Churchill, secretary for the colonies, presided.

Better Garments; Better Service; Better Values

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Here is a Purchase Proposition that you will want to Take Advantage of

Select from the numbers listed below any assortment of Surgeons' Gowns, Patients' Bed Gowns and Nurses' Uniforms, and shipment will be made to you AT ONCE, *carrying charges prepaid*, subject to return, carrying charges collect. At the end of ten days, should the goods prove in your judgment to be other than claimed by us.

We claim every garment to be of the finest materials possible to furnish, to be full-cut, to launder perfectly, and to resist chemical action and blood stains.

This exceptional proposition will bring a flood of orders from those who know of the superiority of this line. You are urged to ACT QUICKLY.

SURGEONS' GOWNS

Surgeons' Gowns are the headliners of our entire line. Made on a foundation of honor, for the most discriminating physicians. Full-cut, shapely, sure to return from the laundry in smart shape. Small, medium, large sizes, resisting chemical action and blood stains.

No. 846—Heavy Indian Head, 60 in. long; long sleeves, per doz., now.....$18.00
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Patients' Bed Gowns

Small, Medium, Large Sizes

No. 28—Pepperell Cloth, double yoke front; wide hems and tapes in back; open all way down; 36 in. long; long sleeves. Per doz., now.....$13.50
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Nurses' Uniforms

Our Nurses' Uniforms are thoroughly practical and at the same time cut in the true style of the day, making them at once sensible and dignified and a delight to the wearer. Sizes 36 to 46—regulation form fitting.

No. 175—Blue Chambray, per doz., now $27.00
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No. 173—Nurses' Aprons—made of Pepperell Sheeting, Separate Bib and Skirt, per doz., now. 18.00

Prices Subject to Change Without Notice

The Hospital Nurses' Uniform Mfg. Co.

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Consult the 1920 Year Book for Catalog information.

QUERIES AND ANSWERS

CONSTRUCTION COST PER BED

To the Editor of THE MODERN HOSPITAL:

In building a modern up-to-date hospital today, including all activities and functions, what is the present estimated cost per bed? SISTER M. C.

The "cost per bed of a modern up-to-date hospital" cannot be categorically stated. It is a question of cubic contents. Modern up-to-date hospitals may vary 50 per cent in the cubic foot allotment per bed, according to the size and development of the laboratories, the presence or absence of an out-patient department, the relative proportion of private room and ward beds, the size of private rooms, the arrangement of wards, the presence or absence of connecting corridors, the proportion of surgical work done and the facilities for such work, the number of nurses sheltered by the hospital, the presence or absence of dormitories for servants, the inclusion or exclusion of a power plant, the development of facilities for physical therapy, the use or non-use of verandas, etc.

I have in mind two plans now in process of development. One of these calls for 250 beds (private rooms and wards) and requires 3,000,000 cubic feet or 12,000 cubic feet per patient. Another, designed for a slenderer purse, calls for 800,000 cubic feet for 100 patients, but there are obvious deficiencies in the latter plan. At the present moment these hospitals would probably cost not less than 60 cents per cubic foot per bed. In some sections of the country it is hoped and expected that the cubic foot cost will be not more than 50 cents by the fall. The figures given contemplate fireproof construction and standard sanitary interior finish.

S. S. GOLDWATER, M. D.

FINANCES AND CHARGES OF THE SMALL HOSPITAL

To the Editor of THE MODERN HOSPITAL:

(1) What should be the annual cost of operating a thirty bed hospital with a daily average of twenty patients?

(2) What should be the rate of charge and how much should the institution receive other than money received from patients to insure financial success? A MATRON.

(1) Presuming that hospital construction and equipment are such that efficiency of service and economy in expenditure may travel together, that the management is capable and careful, the cost of delivering twenty hospital days' service per day for one year (7,300 days) at present cost of supplies and labor would be about $34,000, or an average of $4.25 per day. This presumes that operating room, x-ray, laboratory, and special nursing service are charged as extras and at a rate sufficient to cover cost.

The above figure also presumes immunity from casualties to expensive equipment, such as the breakdown of an x-ray transformer, the necessity for a new washing machine or extractor, and the thousand and one other things that may happen to load up the expense account.

(2) Presuming that financial success is synonymous with mere solvency, the amount of money from sources other than income for service should be enough to fill the gap. For example: collecting an average rate of $3.25 per day, on above basis, would mean a deficit of $7,300.00.

USING STERILIZED MATERIALS

To the Editor of THE MODERN HOSPITAL:

How long after dressings, flat pieces, etc., have been sterilized do you consider them safe for general floor use? HOSPITAL SUPERINTENDENT.

In some operating rooms, enough emergency supplies for ten major operations are always kept on hand in addition to the daily supplies. These emergency supplies are resterilized every two weeks and put away for an emergency or are used for operative cases.

In some general wards, two sets of containers (white enamel cans) are supplied to each ward. One set of containers, with supplies for the following day, are sterilized daily. As these containers are more or less in constant use, and the supplies are subject to contamination by exposure to the air when container is open, daily sterilization is essential.

It would probably not be safe to use supplies which have been sterilized longer than two weeks.

ADVERTISING THE HOSPITAL

To the Editor of THE MODERN HOSPITAL:

What means do you find best adapted to advertising the hospital and its needs? ADMINISTRATOR.

A great many hospitals in the past have exercised a policy of exclusion of the public from all their activities, or at best, have taken into their confidence only a selected few of the community, looking to that few to furnish such material things as the hospitals needed. If the hospital is to be a community institution, in the truest sense of the word, then the community should know what the hospital is doing, and what its needs are. It is probable that if the story of the hospital is told in a newsy way, that the interest in, and the support of the hospital will be much more spontaneous. Local newspapers are always willing to give space for articles relative to the performance of a hospital. Propaganda on nurse training, with specific reference to the hospital furnishing the speaker, is good advertising. The word of mouth advertising of the patients of the hospital is by far the most efficacious. Monthly bulletins, if they are properly prepared, and have a sufficiently large mailing list, are good. Properly staged, and properly conducted annual meetings are also good.

Adv. Page 50

HOSPITAL LINEN REQUIREMENTS

For more than a quarter of a century we have been furnishing linen requirements to many hospitals and institutions throughout the United States, to the entire satisfaction of all parties concerned.

While we have traveling men who cover the United States, we realize that it is impossible to have a man on the ground at all times when you are ready to place your orders, and it is for this reason that we operate a special service department who will forward samples and prices to you upon request without obligation on your part.

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for Attendants

Page 846

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LOS ANGELES
SAN FRANCISCO

STERILIZING USED GAUZE

To the Editor of THE MODERN HOSPITAL:

What method should be used to wash out and sterilize gauze which is used a second and third time for surgical dressings? G. E. P.

The gauze should first be given four cold, breakdown baths, using tri-sodium phosphate. This same method is used with blood-stained surgical goods, and for the same reason. The gauze should then be given a boiling rinse, followed by a bleach. Use no soap. No attempt should be made to iron the gauze in the laundry. As soon as it is returned from the laundry, the washed gauze should be stretched on frames until smooth, when it is folded for dressings, wrapped in small packages, and sterilized for three successive days. This reclaimed gauze is softer and whiter than new gauze. Strips that cannot be used for surgical purposes may be used as mops and wiping rags. The engine room will be glad to get some of them.

DUTIES OF MATRON

To the Editor of THE MODERN HOSPITAL:

What are the duties of the matron of a hospital of one hundred beds, and under whose direction should she be? MATRON.

This position requires an exceedingly practical woman, for, if the housekeeping of an institution of this size is to be conducted successfully, the matron must be a woman of excellent attainments. Her duties are such that she must have the ability to deal with many difficult problems, as she comes in touch with the various classes of people in the hospital.

Her duties vary somewhat, according to the organization adopted by different institutions. In one institution, for example, she may have to manage the domestic affairs of the institution, do the buying, supervise the cooking, and handle the food, and care for the linen. In another institution, she may be relieved of all purchasing of goods, and handling of food, and be confined entirely to the province of housekeeping. If she does this well, she will have all that one woman can do in an efficiently regulated hospital, unless she has a number of assistants. As housekeeper, she would be responsible for the cleanliness and good order of the entire building, including the supervision of the linen supplies and other kindred duties that the superintendent may assign to her.

She would at all times be under the direct supervision of the superintendent.

NOISE OF CONCRETE FLOORS

To the Editor of THE MODERN HOSPITAL:

How can the noise of concrete floors in hospitals be reduced? SUPERINTENDENT.

It is almost impossible to reduce this noise. Concrete floors were intended for factories, not hospitals. Our suggestion is that a linoleum runner be placed in the center of the corridors. This will afford some measure of relief.

SPECIAL PLUMBING NOT NECESSARY

To the Editor of THE MODERN HOSPITAL:

We are building a new laboratory room for our 100-bed hospital. Will you kindly tell us whether it will be necessary to have special plumbing for the sink where the chemical work will be done? Is it necessary to have a special soil pipe? In building a fume closet, can sufficient draught be assured by a gas flame near or within the opening in the flue? DIRECTOR OF LABORATORY.

Ordinary plumbing may be used for laboratory purposes, provided those using the sink will take good care to pour strong, acid solutions into large earthenware jars, which can be emptied outside of the building as required. The sink itself can be used for fairly strong acid solutions, if it has a lead pipe, and if it is flushed out with water after the acid has been used.

With regard to the fume closet, we cannot speak so dogmatically. We doubt whether a Bunsen burner placed in a flue would create sufficient draught to remove the fumes adequately. This could be tried, however, with very little expense. For most of the tests in an ordinary hospital, the use of a flue closet is unnecessary.

PAINT FOR PESTS

To the Editor of THE MODERN HOSPITAL:

Can you suggest a chemical that can be mixed with paint to help in the extermination of fleas and other pests? PAINTER.

There are no chemicals that we are aware of at the present time that would be of any value in the paint to help in the extermination of fleas and other pests. Inasmuch as paint forms an airtight film, it would seem unnecessary to put in an exterminator. There is, however, a hygienic calcimine on the market, containing a chemical which serves as an exterminator. It comes in the form of dried powder, and dissolves readily in hot water.

STERILIZING BEDDING IN SMALL HOSPITALS

To the Editor of THE MODERN HOSPITAL:

What is the best way to clean and sterilize bedding in small hospitals? HOUSEKEEPER.

While many hospitals do completely sterilize their mattresses after a patient has been discharged, this is not absolutely necessary. Take down the entire bed, brush the mattress with a slight disinfectant and deodorant, and let it stand for a period of at least six hours in the fresh air.

DO TRADE UNIONS SUPPORT HOSPITALS?

To the Editor of THE MODERN HOSPITAL:

Do trade unions in the United States subscribe towards the support of voluntary hospitals, and if so, on what basis are such subscriptions obtained and distributed? SUPERINTENDENT.

There is no regular policy among the trade unions, so far as we are aware, of making special grants to support voluntary hospitals. The funds of these organizations are accumulated to defray the expense of their work. Funds are donated frequently in answer to special appeals, and, of course, members in their individual capacity respond to such appeals. Some of the organizations, notably the International Typographical Union, and the Printing Pressmen maintain sanatoriums. Special provisions are included in the laws of these organizations for the revenue to maintain these institutions.

WRITTEN ORDERS FOR NURSES

To the Editor of THE MODERN HOSPITAL:

Should the hospital require physicians to give the nurses written orders? CHIEF OF STAFF.

Yes. No verbal orders of any character should be given by the doctors to the nurses. Orders both for medication and treatment should be written in order books. A good plan to follow is to write the orders given during the day in black and the orders given during the night in red.

CENTRAL LINEN ROOM

To the Editor of THE MODERN HOSPITAL:

What are the advantages of a central linen room? MATRON.

The main advantage of a central linen room is a definite control of linen. If the linen is taken from the laundry to the central linen room, and from there to the wards, the person in charge of the linen room knows at all times the amount of linen in the various wards.

Adv. Page 52

THE NEW METHODIST HOSPITAL, MEMPHIS, TENN.
MR. JOSEPH PURVIS, SUPERINTENDENT.

Complete Surgical Suites

THE Van Vleet-Mansfield Drug Company installed the complete surgical equipment for the first unit of the Methodist Hospital, Memphis, Tenn. This unit, which has a capacity of 150 beds, will be ready to receive patients about October 1, 1921. The contract included the complete equipment for five operating rooms and the maternity department, also two complete sterilizing outfits.

Recognized as one of the most complete installations of its kind in the country, this contract is a fitting testimonial to the ability of this company to furnish varied equipment of the highest quality in competition with the entire country.

The extent of our line is complete including surgical instruments and supplies, laboratory equipment, steel hospital furniture, sterilizing apparatus, electrical equipment, drugs and pharmaceuticals.

Estimates will be given gladly on the requirements of any institution.

Our facilities and our experience enable us to serve you intelligently and satisfactorily. Our geographical location and our large, well-selected stock enable us to save you long delays in transportation.

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Foreign Correspondence

AID FOR BRITISH HOSPITALS

Viscount Cave's committee has submitted recently practical proposals for restoring the financial stability of the British hospitals. This committee was appointed by Parliament to consider and advise on the question some time ago, and it recently issued a report. It has been notoriously evident during the past three years that the greatly increased cost of maintenance due to after war conditions has far outstripped contributions, the outcome of which is that the continuance on a voluntary basis of some of the best known institutions is in grave jeopardy. The main recommendations of the committee are as follows: 1. That a hospital commission for Great Britain should be set up by the Ministry of Health. 2. That voluntary hospital committees should be formed in each county or county borough, the King Edward's Hospital Fund to act for London. 3. That Parliament should be asked to sanction a temporary grant of £1,000,000 ($5,000,000) for 1921, to be administered by the hospital commission, grants to be made normally on the recommendations of the local voluntary hospital committees. 4. That a further grant may be required in 1922, but no government assistance should be promised beyond that year. 5. That the hospital commission during the two years may recommend grants not exceeding £250,000 ($1,250,000) in 1921-22 for extension and improvement of hospitals, subject to like contributions being made from private sources. 6. That arrangements should be negotiated through the voluntary hospital committee for the utilization of vacant beds in Poor Laws infirmaries. 7. That county councils should be empowered to contribute to the expenses of voluntary hospital committees. 8. That failing the provision in the National Health Insurance Acts of a "hospital benefit" the courts should be authorized to award to hospitals compensation under the Employer's Liability and Workmen's Compensation Acts. 9. That local authorities should be authorized to pay the cost of the treatment in hospitals of persons in their employ. 10. That the payment from technical education funds of grants for the training of nurses should be considered. 11. That provision should be made for obtaining and tabulating returns of cases treated in hospitals. 12. That all contributions by employees to hospital funds should be allowed as deductions from profits for income tax purposes. 13. That where the payment to a hospital of a testamentary gift of residue is delayed for more than a year, the hospital should be authorized to claim repayment of income tax. 14. That legacy and succession duty on testamentary gifts to hospitals should be remitted.

Uphold Voluntary System

The chief feature of the report is that the voluntary system is strongly upheld. The suggestion made in many quarters, and especially by the labor party, that liability for the hospitals should be taken over by the state, or thrown upon the rates, or, at least, that a regular yearly grant in aid should be made from one of these sources is condemned wholeheartedly. In the view of the committee either proposal would be fatal to the voluntary system. It feels absolutely certain that the voluntary system is worth saving. It is pointed out that if that system falls to the ground, hospitals must be provided by the public, and the expense of so providing them would be enormous. They must then be carried on without the aid of the voluntary subscriptions and donations estimated at not less than £3,000,000 ($15,000,000) a year, and presumably without the income, about £1,000,000 ($5,000,000) a year, from endowments which were given to support voluntary hospitals only. But, in the opinion of the committee, the money loss to the state should be a small matter compared with the injury which would be done to the welfare of the sick for whom the hospitals are provided, the training of the medical profession, and the progress of medical research. It may be mentioned that in Great Britain there are 952 hospitals, containing 52,194 beds. The beds in the Poor Law infirmaries are considerably more numerous. In this connection the committee considers it unfortunate that the abundant and varied clinical material in Poor Law infirmaries should be hardly used at all in the training of medical students. Moreover, the committee is informed that during the winter months there are, on an average, over 20,000 vacant beds for sick persons in Poor Law institutions and that during the summer months the number increases to over 30,000; and it is thought very desirable that these beds should be used, if possible, for reducing the long waiting lists at the voluntary hospitals. The committee insists that if the voluntary hospital system is to continue and prosper it must rely not only on the large subscriptions and gifts, but also, and to an increasing extent, on moderate and continuous contributions from all classes of the community. During recent years appeals to those engaged in industry to make a weekly contribution out of their wages have become more frequent, and the ready and generous response made to these appeals is perhaps the most encouraging feature which has come under the committee's notice. The request of the committee makes but slight reference to payment by patients, it sees no reason why this practice should not be generally followed, provided that great care is taken not to exclude the very poor from benefits which were primarily intended for them. As for insured persons, while the committee holds that approved societies are not under any obligation, legal or equitable, to provide the whole cost of the maintenance and treatment of their members in hospital, it is strongly of the opinion that they do owe to the hospitals a large measure of support. The suggestions made in the report are valuable and if followed, will, at any rate, relieve the hospitals of their

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immediate embarrassments and give those responsible for their management time to consider the situation from all angles and devise schemes accordingly. No doubt better organization, coordination, and shrewder business methods will do much, but at the same time, it seems that a wider introduction of the pay system might serve to place the hospitals on a firm financial basis. This might be brought about without militating against the voluntary system.

* * * *

NURSING QUESTION A LIVE ISSUE

The Honorable Sir Arthur Stanley, the head of the British Red Cross Society, presided recently over a joint meeting of the committees of the British Women's Hospital, Nation's Fund for Nurses, and College of Nursing, Ltd., held recently at the Automobile Club, London. In the course of his speech he referred to the fact that during the two and a half years of its work the British Women's Hospital Committee had accumulated a total of £148,915 ($744,575) for the Nation's Fund for Nurses. Of this sum, £78,401 ($372,005) was received specifically for the tribute fund, £18,863 ($94,315) for the College of Nursing, Ltd., and £50,000 ($250,000) for general funds. The tribute fund for the relief of individual nurses included a capital grant of £50,000 ($250,000) from the British Red Cross Joint War Committee, £10,000 ($50,000) collected in Ireland and returned to that country, the interest to be expended on Irish nurses, and £2,767 ($13,835) from the Women's Emergency Corps for Pensions.

A large proportion of the general funds was derived from the promotion of entertainments which brought in a net sum of £32,538 ($162,690), the expenses being under 3 per cent. The total expenses of the fund over a period of two and a half years amounted to £8,057 ($40,285). The committee, Sir Arthur Stanley stated, aimed at a capital of £100,000 ($500,000) both for the College of Nursing, Ltd., and the tribute fund, the interest of which would be available for carrying on the work of each. Up to the end of 1919, they had in the tribute fund £78,401 ($392,005). He did not wish to anticipate the report of 1920, but he thought that he could give the gratifying information that during the past year they had reached £100,000 ($500,000). As regards the College of Nursing, they were still far short of the capital sum required.

Attention has been drawn previously to the unsatisfactory state in which British nursing is at the present time. The supply of skilled nurses is woefully inadequate for the needs of the population, and as the various schemes of the Ministry of Health, such as the establishment of rural hospitals and maternity institutions, develop and mature, as some of them surely will, the necessity for skilled nurses will be even more urgent. Hospitals cannot be conducted properly without the aid of competent nurses, nor can any institutions in which the sick or injured are treated. Good nursing, which means skillful nursing, for however well intentioned the nurse may be, without effective training she is incompetent, is as essential to the recovery and well-being of the patient as is medical treatment. Without satisfactory nursing, the medical man or surgeon is more or less helpless.

The supply of skilled nurses in Great Britain at the present time is comparatively small, not nearly equal to the demand. The act compelling the registration of nurses has only been passed and come into force recently. Its provisions are retroactive, and unregistered nurses, some of whom are presumably unskillful, become registered. It will take a few years to weed out such as these. Moreover, the system of training nurses in vogue in this country is defective in some respects. A girl wishing to join the nursing profession must be twenty-two years of age before the best hospitals and schools of medicine will admit her as a probationer. It seems that the age limit for beginning training should be lowered. Many girls well adapted for nursing cannot, or do not wish to wait so long before beginning their training. The majority probably cannot afford to do so, and the remainder do not wish to waste their time or to undertake other work which they would be forced to relinquish when they arrive at the age when the hospitals are willing to receive them as probationers.

Up to quite recently, too, the pay of nurses has been beggarly, and the manner in which they have been treated as to accommodation, food, and so on, has not tended to make nursing a popular career. A good many of these disadvantages have been removed of late, the pay has been considerably increased, hours of duty have been lessened, and a great deal more attention has been paid to the comfort of these really hard worked women. This has been notably the case at the London Hospital in the east end of London, whose policy is directed by that energetic and able organizer, Lord Knutsford. Notwithstanding the improvements which have been effected in this direction, "much water will flow under the bridge" before anything approaching perfection is attained.

After all, the nursing question, like the hospital question, of which it is, of course, an integral part, is largely a financial one. If means are not devised to place the hospitals on a sound basis financially, how can the authorities of these institutions afford to pay their nursing staff more than double their former salaries? Indeed, the nursing problem is a part of the hospital problem, and a satisfactory solution of the one will provide a satisfactory solution of the other. The solution of the hospital question still seems far off. The matter does not appear to be approached boldly, but the idea seems to be to tinker with the existing mode of management so as to bolster up the voluntary system. There is no doubt that a decision must be arrived at soon, as it is becoming more and more evident that to depend upon charity alone for the support of the hospitals is leaning upon a broken reed. A compromise scheme must be thought out, and who is so able to undertake this task as Sir Napier Burnett, director of the hospital services of the British Red Cross Society?

There is no reason why the voluntary system should be abandoned *in toto*. In fact, public sentiment is strongly against such a proceeding. Yet it appears that the voluntary system might be retained as to essential features, and at the same time, paying wards might be introduced, in which all who are treated as hospital patients, should pay according to their means. Absolutely indigent patients should be treated free, either at the cost of the ratepayers, or the nation, or both. In addition, insurance patients should certainly pay for treatment, especially as it has been shown recently that the British approved societies have an immense surplus. The manual worker now is in a position to pay for treatment, and if he is not willing to do so, pressure should be put upon him. As Napier Burnett has said, educational propaganda is needed to make the mass of the population realize their duties and responsibilities towards the hospitals. The hospital system will be greatly extended in the not far distant future, and with it the need for more well trained nurses. As said before, and this may be emphasized, the questions are bound up together and ultimately are problems of organization and money.

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

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OPPORTUNITIES FACED BY THE AMERICAN HOSPITAL ASSOCIATION

L. B. BALDWIN, M.D., University of Minnesota Hospital, Minneapolis, Minn.

OFFICERS of the Association, in the past, have outlined what may be called the successive ages through which the American Hospital Association has passed. These ages or periods of development have been sympathetic to the needs of the time in the growth of the hospitals of the country which the Association has aimed to promote. They have been suggested as:

First, the period of the development of the hospital superintendent, of the man or woman who had to man and to make the institution he or she served.

Second, the period of hospital organization promoted by the establishment of the Association's headquarters and by the creation of bureaus and committees and state sections to study and apply standards of hospital function.

Third, the period of today upon which the American Hospital Association is consciously entering—the period of hospital service in the interest of the community the hospital serves.

It is my purpose to suggest some of the activities by which the service of the hospital to the community may be effectively and efficiently realized.

We have arrived at a time when the value of a public institution is to be measured in terms of social service rendered. It follows that the value of an association of institutions is to be measured by the success with which it promotes such service.

It is pertinent, therefore, to ask what functions the community expects or should expect the hospital to perform, or to the performance of which it should contribute. Valuable information and suggestions on this subject have already been contributed by such men as Dr. Haven Emerson[1] and Dr. Winford H. Smith,[2] and could not be better expressed than in the terms they have employed. In logical order so far as hospital service goes they are stated as:

1. The diagnosis and treatment of the sick.
2. The teaching of medicine.
3. The prevention of disease.

There has never been a time when the part that the hospital should play in the diagnosis and treatment of the sick has had the public recognition and created the public demand that it does today. It will be an increasingly large part in the future.

"In view of the foregoing observation," said Dr. Baldwin, in his opening presidential address, "I would suggest that the Association take early measures toward the creation of a bureau on community hospitalization, organization, and administration; that it provide experts for the study of social needs and the information and assistance of community officials in these matters, whose services shall be given at reasonable charges going toward the maintenance of the bureau, which should be directed by a competent full-time chief. The constructive work possible of accomplishment by such a bureau is incalculable in its range and results. It might be possible, but doubtfully wise, to add this work to the function of other existing bureaus."

1. The Survey Report of the City of Cleveland.
2. Address, Annual Conference on Medical Education and Hospitals, Licensure and Public Health, Chicago, 1921.

There has never been a time when it was so necessary that the hospital should so fitly fulfill its teaching function, when it should so freely serve as the medium through which the medical light of today may be handed down to the medical generations that are to follow.

There has never been a time when the social consciousness of our people has been so awake to the interests of public health and to those principles of disease prevention which the hospital should promote.

Suitable Classification of Hospitals Needed

How may the American Hospital Association answer to the communal need of the country in the way of hospital service? The leadership of such an organization as this may do much by way of social direction.

An initial step is to secure a suitable classification of hospitals and to educate the public in the recognition of the nature and qualities of the institutions so classified. This classification should be dictated by the consideration of the sort of service the hospital renders, rather than by the means or method of its support. At once the private hospital, whether created by endowment or by gift, whether sustained by denominational bodies or by groups of physicians, falls into one large group. The major part of, and often the exclusive service that it renders, is to the patient who can pay. It may do beneficent service, as every hospital should, but it is not in any true sense entirely a charitable institution. Because, occasionally, it supports or secures endowment of a few free beds, it is not entitled to that term. It were better, perhaps, if it did not have any. It is essentially a hotel for the sick, in which room of varying quality and cost, board, nursing and domestic service are provided at a varying charge. It is a business enterprise. The public should expect it to be at all times solvent and self-supporting. Its deficits should be relieved by better business administration, by better budget control. It renders a social service to the sufficiently well to do and at a paying price.

Many Must Depend on Public Hospitals

Large numbers of the people who are sick cannot patronize the hotel for the sick. They are indigent at all times, by fault of persistent failure in health or inabilty of self-support. Or, as frequently, they are temporarily dependent upon social help because of illness; economically efficient under favorable circumstances they are easily crowded to the financial wall by the added expense of sickness or the consequent inability to work for wages. They are subjects, not of charity, but of that measure of social justice which seeks to level the scales of inequality and misfortune. They call for the sort of service for which the second great group of public or general hospitals, under state, county, municipal or village control exists. They are supported, and should be amply supported by taxation. In capacity, from the general hospital, in the several departments of which all forms of disease are cared for, to the small community hospital, often not more than a house, which every village may and should support, in which one or more rooms or small wards are well equipped for the care of the occasionally sick of the village, they vary widely. They should have adequate space not only for sick indigents but for those who may desire and be able to preserve their sense of self-dependency by the payment of a per diem charge —to be regarded as a special tax for hospital support.

Into a third group falls the teaching hospital attached to university medical school or college; supported by the state or by the teaching institution itself. It is as well to recognize this university relationship of the teaching hospital because the medical schools are rapidly passing under university control and because those that have not so seldom may boast of a teaching hospital.

The hospitals of this group exist for educational purposes. Their patients are selected and their retention governed by the purposes. By the fact of their teaching, in which all hospitals should share, but for which other hospitals do not specifically exist, they must make the superlatively good care and treatment of the sick their prime consideration. They must necessarily cultivate the diagnostic feature of their work and should support diagnostic clinics for the benefit of the sick through the medical profession at large. Custom dictates the social status of their inmates who may be termed pay, per diem or free patients. Two principles only need govern this question. Pay patients should be referred by physicians. The fees they pay should go to the institution and not to the staff.

The hospitalization of every community, large or small, should be made a matter of social survey and hospitals of each class should answer directly to social need, so far as it exists. The public hospital is always a necessity, be it big or little. Under favorable circumstances temporary arrangements for the care of the indigent or economically disabled sick may be made by the town or village with a pre-existing private hospital, but in that event it should be under public supervision, its free or per diem wards should be supported by taxation and a special section of its budget should cover their operation. Too much emphasis cannot be put upon the necessity for

the provision of more hospital accommodations, at moderate cost, for those of greatest number in every community, who are of slender means. The temporary help, under some form of per diem payment for hospital service of those whom sickness puts upon the financially sick list, comes only second in importance.

Every such public hospital and even selected private hospitals, should be in close affiliation with the public health service of the community for the hospitalization of venereal and other communicable diseases. It is to the reproach of communities and our existing hospitals that but rarely may an institution be found which willingly admits infected persons of this class, whether poor or able to pay for service. While such patients should be under the medical or surgical care of the hospital staff, their quarantine or isolation should be under the control of the public health officer. From the hospital many of these venereal cases, so commonly associated with mental incompetency, should be dismissed, under similar control to a retention home.

Political Influence Obstacle to Service

One of the principal obstacles to the best community service of the public hospital must be recognized in the invasion of political influence into its governing mechanism of whatsoever type. It is a truism that this evil if not incurable is at least difficult of cure, save by the purification of our political systems as a whole—at present but a millenial prospect. Undoubtedly there is a choice of the method of control in the achievement of the most direct responsibilty, whether of governing board, hospital administrator or general health officer in charge. Preference may be urged for the appointment, by the highest officer of the local government of a single official to whom the public health and hospital interests of the community should be entrusted without responsibility to any but the appointive head and without liability to removal save for established cause.

The authority of the administrator, director or superintendent of the hospital, of whatsoever type, should be adequate to the effective administration of the institution under his care. Conflict of authority between his office and that of the chief of staff or superintendent or nursing should be carefully safeguarded. Staff functions should be defined and scrupulously respected. In all matters of controversy the superintendent should be the final referee. If there must be a governing board over a public or a teaching hospital or a board of trustees over a private hospital it may wisely be of small membership. The inefficiency of the board of numerous managers is notorious and a common cause of at least partial paralysis of the executive. A governing board should delegate to its executive a free hand and should reserve to itself only the power of review over the general policy of the institution, the initial approval of the budget and of the award of contracts recommended by him.

Should Provide Training for Executives

It is to be confessed that efficiency is not always the property of the hospital executive. The earlier efforts of the Association toward development of a higher type of executive should be perpetuated to the point of providing the means of actual training for this service, of attracting a high type of men and women to it and of the ultimate development of superior and better paid administrative quality.

The time has come—its coming has been recognized in some of our institutions—when the function of the hospital in the training of nurses should be transferred to educational institutions of university or college type, with which the hospital should affiliate for the purpose of giving to nursing students their laboratory or clinical opportunities. The university schools of nursing are multiplying. The Cleveland Survey commends them. They are setting new and needed standards. They are promoting a more attractive registration. The University of Minnesota has recently effected an arrangement between three other hospitals and its own teaching hospital for the maintenance of a single school of nursing, using the clinical service of the entire group for training, and assigning student nurses in succession to each. Such an association makes for a more complete and varied training of the nurse, for the standardization of nursing education and the development of a university spirit in its students.

Need Efficient Business System

Much remains to be done—without which real community hospital service cannot be achieved—in the cultivation in hospitals of every type, of an efficient business system, and to this vital need the American Hospital Association should address itself. That the usefulness of too many of our institutions is limited by the dry-rot of business inefficiency is very evident. The want of a budget, loose methods of purchasing, inadequate cost-accounting or none, the consequent lack of any basis for the proper scaling of the costs of service rendered and of charges to be paid for such service—these are faults which go far toward an explanation of the poverty, the annual deficit, the imperfect equipment of hospitals otherwise capable of good service.

In view of the foregoing observations I would suggest:

Dr. Baldwin Makes Three Suggestions

First: That the Association take early measures toward the creation of a bureau on community hospitalization, organization and administration; that it provide experts for the study of social needs and the information and assistance of community officials in these matters, whose services shall be given at reasonable charges going toward the maintenance of the bureau, which should be directed by a competent full-time chief.

The constructive work possible of accomplishment by such a bureau is incalculable in its range and results.

It might be possible, but doubtfully wise, to add this work to the function of other existing bureaus. Its specific quality suggests a distinctive organization.

Second: That the Association recognize the possibilities of progress to be realized in its most active participation in, and cooperation with the American Conference on Hospital Service. The interrelations of a body concerned with the attainment of the highest order of hospital service, with such organizations as compose the Conference are, or should be, very close.

Third: Because of the relatively small number of institutional memberships at the present time the membership of the Association imperfectly represents the hospitals of the country. The merit of a fee graduated to the size of the hospital is questionable. Would not an institutional membership fee alone of $10.00 secure the initiation of most of the many hospitals not now represented and at the same time yield a revenue adequate to the Association's needs and to the important public service it has to render? The addition of every single hospital adds to the potential energy of the Association which it is our aim to fully actualize.

A HOSPITAL FOR 1,500,000 DOWNTOWN NEW YORKERS

By A. J. BARKER SAVAGE, Superintendent, Broad Street Hospital, New York; Consulting Superintendent, Community Hospital, New York, the Harbor Hospital, Brooklyn, N. Y., and the Memorial Hospital, Staten Island, N. Y.

ON THE first day of August about two hundred of the business leaders of downtown New York set about raising a $1,000,000 fund for building another wing for Broad Street Hospital, a hospital that will have to bear the brunt of the emergency accidents and illnesses of the largest transient community, and the regular illnesses of one of the smallest resident communities in the world. For four years the hospital had been in operation, doing whatever it could to take care of the casual illnesses of the 1,500,000 commuters who flock to the Mecca of business that is included within the bounds of Chambers Street, the North River, New York Bay, and the East River. Then came a disaster that called the attention of the business men to the hospital in their midst. A bomb exploded at the corner of Wall and Broad Streets, almost in the front yard of the hospital. One hundred and seventy-three victims were brought into the 100-bed hospital in a single hour. Even to the doors that open onto the Bay on the one side and to the street of finance on the other, the hospital was filled.

There was no doubt of the hospital's value then. Yet it was the only general medical and surgical institution in the district. With one other hospital it was to cope with the emergencies of America's financial, commercial, and shipping center. Of course, such an accident would not come every year, and it is to be hoped such an accident will never recur.

But business men began to make a study of the illnesses that occur in their own establishments. Throughout all lines of activity it was found that on the average three persons out of every one hundred were sick each day. Over 45,000 of the 1,500,000 workers in this district were absent from work because of illness. The average worker was losing nine days a year because of illness. Yet in a number of the institutions where medical departments are highly developed or where cooperation with the hospital had been established the rate was found to be lower. The absence rate had been reduced from three to two per cent in one of the large banks, and to one and one-half in another.

It was clear, then, that such organizations as the American Telephone and Telegraph Company, Guaranty Trust Company, the Federal Reserve Bank, the Chemical National Bank, the Bankers' Trust Company, and the United Fruit Company were finding it a matter of good business as well as the duty of a humane employer to take care of the physical welfare of the employee; that a committee, which came to be called the Downtown Hospital Association, was justified in its hope

that a lower illness rate and a better standard of health would be the result of extended hospital facilities.

The result is that they, themselves, undertook the completion of the next unit of the hospital that will double its capacity and reduce from 8,600 to 5,500 the proportion of daytime population to each hospital bed in lower Manhattan. At night, since the resident population of the district is but 18,000 and the number of hospital beds in the district is 175, the ratio is about one hospital bed per one hundred persons.

If an increased hospital service for so large a community results in even a slight lowering of the rate of absence in industry due to illness, the direct financial saving is going to be considerable. Illness is now causing the loss of about a third of a million dollars each day in that square mile of New York alone.

In another respect, too, physical impairment is taking its toll. Professor Irving Fisher of Yale has estimated that the average age of persons at death is fifteen years less than should be the case. He has said that careful attention to health and the signs of illness would cause a lengthening of life and of the span of activity. A study of mortality statistics in those countries where they are available for any great number of years shows already there has been a great lengthening of life, and gives confidence in the truth of the statement of Professor Fisher.

And life can be lengthened even more among the working men and women of lower Manhattan. Feverish and worried activity, interrupted often only by a hasty luncheon not wisely selected, cannot be the best training for the man who would live long. The service that a hospital can do, not only in curative but also in preventive work, in this district is inconceivable.

But the completion of the building program of the hospital is important for another reason. It is to result in a further expansion of the idea of group medicine in New York City. For the plan of the hospital is to enlarge from seven to a dozen, the group of physicians and surgeons who conduct hospital examinations of unusual cases, having specialists in the various branches of medicine cooperate in the diagnosis and treatment of difficult cases.

In this manner the theory, in which Dr. James F. Mumford of Harvard University was the pioneer, is to be further expanded with the idea that the patient whose symptoms do not at once give him a certain classification will be subjected to an examination by men qualified in particular subjects.

Prospectus Showing the Proposed Addition to the Hospital

There will be a diagnostician whose function is to be that of judge of the findings of the various specialists, who shall coordinate their reports and draw a conclusion from them.

The Hospital to Be a Diagnostic Center

Under a system of individual diagnosis, traveling from one specialist to another entails much waste of time and necessary expenses in fees, drug bills, expensive apparatus, and perhaps trips to health resorts. Could the patient be examined by a number of competent men at one or a few sessions, a diagnosis could often be made at once and the proper treatment instituted.

THE POTTER METABOLIC CLINIC OF THE SANTA BARBARA COTTAGE HOSPITAL

By W. D. SANSUM, M.D., Director, Potter Metabolic Clinic, Santa Barbara, Cal.

DURING the past few years many important medical discoveries have been made. This is reflected concretely in the vital statistics which show an increased life expectancy of more than ten years. Few people realize that this has been accomplished largely through the efforts of medical research. Much of this work has been done through the individual efforts of medical men and with very little moral or financial support from the public in general. The outlook for medical research, however, is brighter today than it ever has been before. Philanthropic corporations and individuals are realizing that the donation of money for medical research that will aid in the prevention of sickness rather than its immediate relief is by far the more efficient type of charity.

The Potter Metabolic Clinic is unique in that an ideal unit for the study of a certain unsolved group of diseases was planned, and fortunate in that philanthropic friends of the Santa Barbara Cottage Hospital furnished sufficient funds to carry out such idealistic plans. The plans were conceived and developed by the late Nathaniel Bowditch Potter and due credit should be given to him. At a recent meeting of the board of directors it was voted to change the name of the clinic from that of The Memorial Laboratory and Clinic, to The Potter Metabolic Clinic, in honor of its founder.

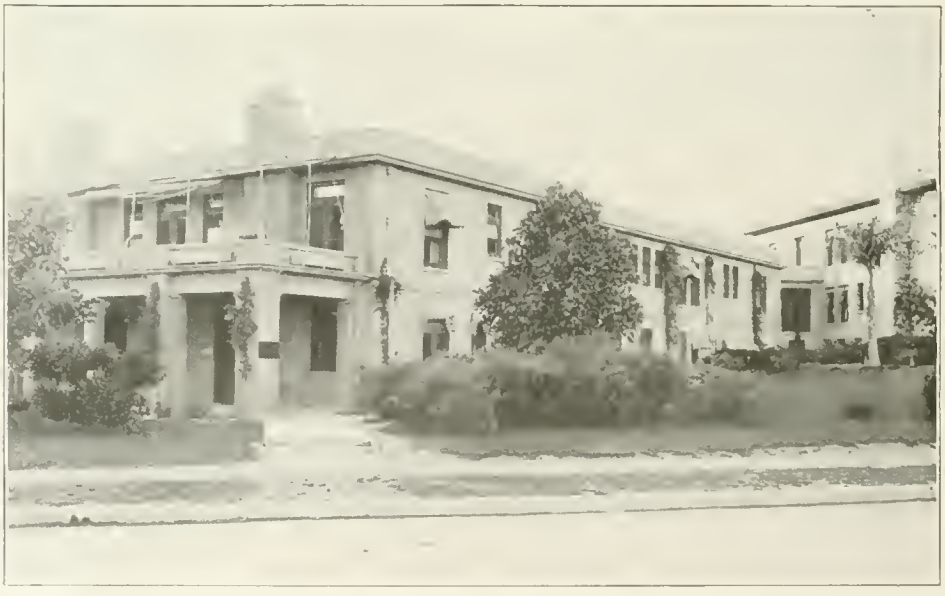
The objects of the clinic are:

1. To make possible a study of a limited group of more or less closely allied diseases known as the diseases of metabolism. These diseases include diabetes, nephritis, high blood pressure, thyroid diseases, gout, obesity, and various other forms of nutritional disorders. This study is intended to be a concentrated effort to ascertain the fundamental causes of such diseases, better methods of treatment, and eventually cures.

2. To furnish a place where patients suffering from such diseases may receive careful, adequate examinations and the best treatment known to medical science regardless of their financial circumstances.

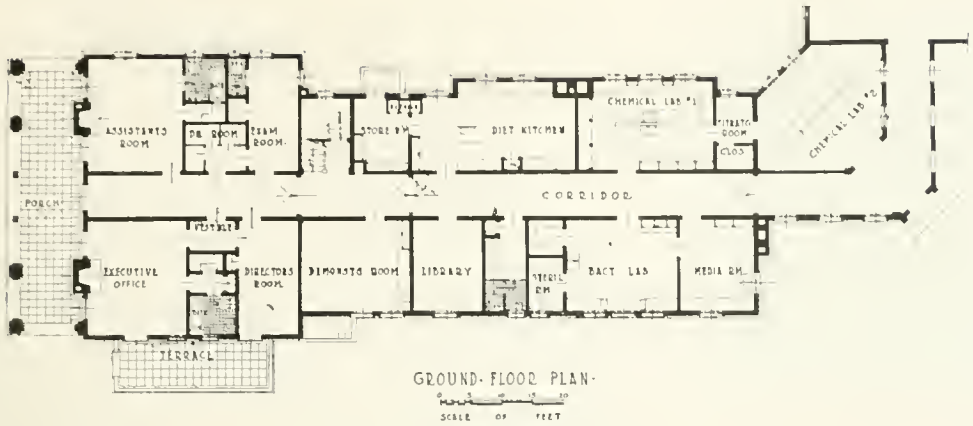
3. To afford a center for the special training of physicians, nurses, dietitians, and laboratory workers interested in this type of work.

The clinic is housed in a specially designed, concrete, two story wing of the Santa Barbara Cottage Hospital conforming to its California style of architecture. The first floor includes the executive offices, quarters for the resident physician, examining rooms, library, diet kitchen, classroom, and five chemical and bacteriological laboratories.



The Potter Metabolic Clinic is housed in a specially designed concrete building, a wing of the hospital, which follows the same attractive style of California architecture.

The second floor includes three three-bed wards, eight private rooms, a parlor, nurse's office, diet pantry, and duty room. The wards are large. Seven of the private rooms have sun porches, five



The ground floor plan.

have private baths and two have fireplaces. Several of the rooms are arranged so that they may be occupied *en suite*. The diet pantry is directly above the diet kitchen and connects with it by a hydraulic dumb-waiter. The duty room is above the laboratories and connects with them by a dumb-waiter.

The non-infectious character of these types of diseases permitted more liberties in decorations, draperies, and furnishing than is usually found in a hospital. The walls, woodwork, and furnishings are stencilled and tinted in soft colors harmonizing with the general scheme and yet giving to each room an individual, homelike appearance. The decorative scheme was that of Mrs. N. B. Potter, who gave to it the same careful attention that would have been given to an ideal private home. This phase of the clinic merits a special description since it is a departure from the usual hospital plan. The following descriptive paragraphs of the decorations and furnishings were written by Mrs. Potter.

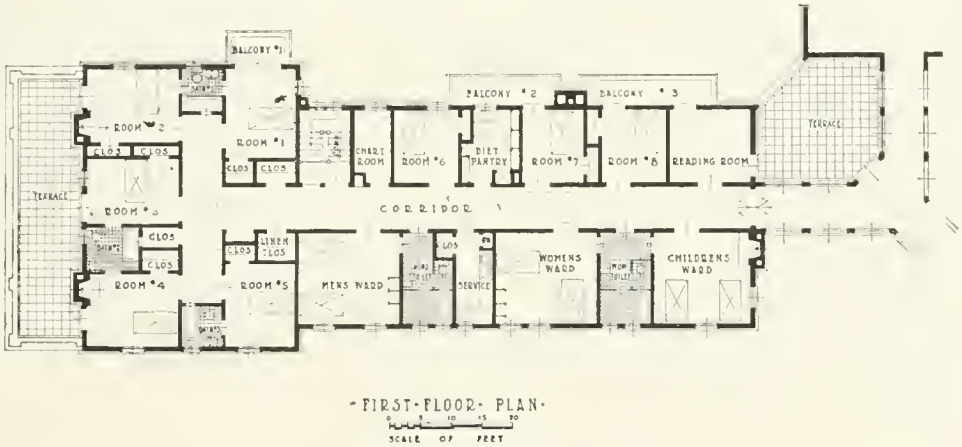
"In planning the color scheme and the furnishings of the rooms, the principle was constantly borne in mind, that the spirit of man, often unconsciously is depressed and wearied, or cheered and rested by its surroundings. Harmony of line and color induces repose and peace while confusion of detail and ill assorted colors produce mental weariness and often nervous irritation. For hospital work a beautiful color is as sanitary as a drab one, and no more costly. The climate is another factor in the selection of colors. Cool, refreshing effects for a warm climate, and color of more depth where an atmosphere of warmth is desired. Bearing these general principles in mind, the following scheme for the clinic in Southern California was carried out.

The softly colored walls of the director's room make a suitable background for black wicker furniture. The chintz of black and yellow design with a few touches of turquoise blue show as careful planning as the room of a private home.

"The building was turned over with red concrete floors, white plaster walls, and unstained wood-work throughout.

"All doors, instead of the usual finish of highly polished oak or mahogany, are stained and rubbed down to a soft brown, which resembles the beautiful French walnut. The door and window trimmings, which are narrow and inconspicuous, are painted a light green, thus immediately introducing a pleasing note of color.

"The walls throughout the building, with the exception of the reception room and director's office, which are pretty colors, are left a warm white. On the walls of the bedrooms is added a three-inch band of color, forming a panel on each wall, with broken corners containing a rosette of contrasting shade. The



The first floor plan.

This bacteriological and pathological laboratory, with its up-to-date equipment, does its part toward realizing the first object of the clinic, which is to make possible a study of the diseases of metabolism.

floors were all stained a green black, and finished with oil and wax.

"The furniture including the beds is stained or painted a soft green instead of the usual hospital white. The colors in the wall designs are in all instances repeated in the simple chintz curtains, the prevailing colors throughout for both striping and linens being yellow with variations in rose and green.

"Special attention was also given to the lighting system, for nothing can offset the dreariness of a room which is lighted from the ceiling. A switch by the door connects with green painted brackets on the wall beside the bureau for convenience in dressing. In addition there is an excellently planned reading light beside the bed.

"Plain taupe rugs are used throughout. This quiet floor covering prevents weariness to the eye, often caused by lying and looking at a poor design which seems to rise and challenge the nerves.

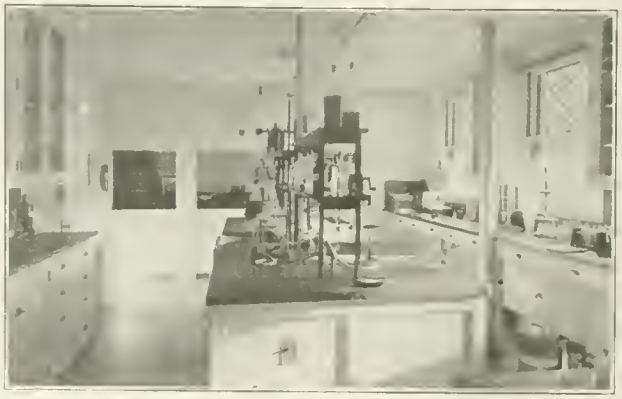
"The harmony of the scheme may be appreciated by the description of some single rooms. For example, one room with its open fireplace and French door leading onto a porch has the green woodwork and furniture, a soft yellow stripe on the wall with dull rose rosettes, and yellow linen draperies with a design of soft roses in simple lines. The high note in the room is the comfortable wicker armchair, painted a beautiful yellow, instead of the more usual drab varnish. The room opposite, ordinarily occupied by a woman patient, has the striping in exquisite cool rose, the curtains a soft green with the same delicate rose design as in the yellow linen, and the same green stained furniture. A rose, wicker armchair, with cushion of chintz makes the note of color against the white wall.

"The small wards are treated in the same fashion as the rooms. The long corridor from which open the patients' rooms is to be completed by a series, on either side, of painted green flower stands holding great ferns, the special gift of a friend whose motto in life has been 'cheer.' The impression of cool, quiet, restfulness, as one looks down the long vista, is indescribable.

"On the ground floor the warm, pretty colored walls of the reception room form a good background for black wicker furniture. The chintz for curtains and covering of the comfortable armchairs is of a fine Directoire design in black and yellow. A few touches of turquoise blue relieve what might otherwise be monotonous. The director's room has the same plain walls, with a blue carpet and a fine English design of birds in the narrow curtains which frame the long window. With only its big mahogany writing table, a bookcase, chairs, and day-bed it is essentially a room for study and thought, but at the same time one which seems to hold out a welcome to the sufferers, who often, alas, may receive bad as well as good news within its walls.

This very attractive diet kitchen is on the first floor and has a hydraulic dumb-waiter connecting it with the diet pantry directly above.

"The china for the trays was selected with a view to the general harmony. Special care was also used in the choice of vases for the patients' flowers, and in consequence every vase is adapted in color and form to showing flowers to their very best advantage, thus adding one more pleas-



The clinic is unusually fortunate in having five chemical and bacteriological laboratories, of which this is one.

ure to the eye. Here again time and interest rather than elaborate expenditure will produce the desired results.

"The expressions of pleasure and comfort from patients of all classes do appear to justify this new venture in hospital furnishing. Thus it will be seen that the essential consideration in the furnishing of the building has been the maximum bodily comfort for the patient, combined with whatever means of cheer and contentment of spirit can be afforded by harmony of surroundings."

The location of such a clinic in connection with a highly standardized, general hospital reacts to the mutual benefit of both. The clinic uses the x-ray, surgical, medical, pathological, and other departments of the general hospital. All of the laboratory work of the general hospital including the basal metabolic rates is done in the laboratories of the clinic. The dietitian of the clinic is also the chief dietitian of the entire hospital. She has charge of the dietetic training of the student nurses and also gives a special, practical course to college graduates who have specialized in dietetic work. All the special diets of the general hospital are served from the diet kitchen of the clinic.*

Even the dietitian's office and demonstration room has a different air, and no wonder when one considers the taste displayed in its furnishing.

This is hardly the cheerless picture which the word "ward" all too often brings to mind. Its taupe colored rugs, pale green furniture, and bright chintz give it a gay air.

The location of the clinic in Santa Barbara with its mild, equable climate was done primarily for the benefit of the patients and such ideal surroundings have both attracted patients and added much to their improvement. It also adds materially to the efficiency of the staff since its members may live within a short distance of their work and thus save both time and energy that might otherwise be spent, in a large city, in the daily travel from their places of residence to the hospital centers. Thus far there has never been a lack of sufficient material for study. Traveling expenses have frequently been given to poor, needy patients who otherwise could not avail themselves of the advantages offered.

The clinic has a small endowment, about one-half of the current expenses are paid by the Carnegie Foundation for the Advancement of Teaching, the remainder is raised by public subscription.

The clinic has an agreement with the Santa Barbara Cottage Hospital which is intended to react to their mutual benefit. In general, the hospital assumes the cost and care of the patients and takes the income from the beds. The ward rates are $3.00 per day. The private room rates vary from $5.00 to $10.00 per day depending upon the type of accommodations desired. The clinic supports the research work and the endowed beds, and takes the income from the laboratory workers on its pay-roll.

*The detailed organization of the dietetic department was presented in the August issue of this magazine.

The private rooms are furnished each with a different colored border around the panel of the wall, with a contrasting color for the flowers in the corners. Even the vases which hold the flowers have been the subject of study and thought.

BUILDINGS EXTREMELY INTERESTING

The buildings of the Peking Union Medical College are no less interesting than the institution of which they are a part. They have required years in building and they are quite unique in the world. They will constitute one of the show places of the eastern capital. And while the exterior is a consummation of all the best in eastern art, the interior is provided with all the latest conveniences.

THE HUMAN SIDE OF THE MODERN HOSPITAL

By ARTHUR PEABODY, Wisconsin State Architect, Madison, Wis.

IT HAS frequently occurred to me to wonder, having never passed a single moment in a hospital bed, how the regular patrons of such places pass the time between the days of acute illness and the recovery of health. The first introduction into an institution is of course a time of purely self regarding interest. What the hospital is, how it is managed or where one's meals come from, is of small moment to a person whose mind is filled up with dreadful visions of surgeons and instruments. The last days, when the world, as one knows it, suddenly comes back to mind, with family, business, motor cars, and golf, are equally absorbing, so that hospitals are no longer of interest.

To lie on an iron bed watching the sunlight creep across a grey wall on which nothing but the faint marks of the cleaner's rag can be discovered . . . is no particular help to convalescence. . . . Could hospital wards be made more human? Is there any chance for mitigation of "strictly sanitary" surroundings that will lighten the tedium of convalescence? Is there anything therapeutic in pleasant suggestion? Would a change of appearance hasten recovery, supposing the interval of crisis to be past? Even in the midst of trial, and every illness partakes of this aspect, would anyone be more ready for the fight if there were a spot of color on the wall, or a bit of softness as of a rug on the floor?

The between time however; those days of waiting for wounds to heal or temperatures to settle down to normal, what about them? I should think they would be hateful in their dullness. To lie on an iron bed, watching the sunlight creep across a grey wall on which nothing but the faint marks of the cleaner's rag can be discovered, the feeling that endless areas of similar walls are being stared at by countless other "cases" for days and weeks on end; that is no particular help to the progress of convalescence. What do they amuse themselves with—these prisoners of hope? None of the wards that I have visited or designed are different, one from another, except that some have one window where others have two. I suppose first rate patients set their minds firmly to the business before them, and diligently strain to add one tissue to another until the great day of the official pronouncement that they are as good as new. Perhaps on the other hand they are bored to death, waiting for this to happen.

Patient May Read Dull Books

One man told me that he took advantage of the occasion to read books that are too long and too dull for ordinary perusal: Robinson Crusoe, Pilgrims Progress, and novels of the Seventeenth Century. Not every person, though, has the reading habit well enough in hand to make ready for a period of this kind. Some are contented simply to be where things are pleasant.

Now that is what I am coming to. Could hospital wards be made more human? Is there any chance for mitigation of "strictly sanitary" surroundings that will lighten the tedium of convalescence? Is there anything therapeutic in pleasant suggestion? Would a change of appearance hasten recovery supposing the interval of crisis to be past? Even in the midst of trial, and every illness partakes of this aspect, would anyone be more ready for the fight if there were a spot of color on the wall, or a bit of softness as of a rug on the floor?

To the scientific mind, a person in a hospital is a "case." At the same time, from other angles, he has every appearance of a human being. Ordinarily he has lived in a house, taken his meals from pleasant looking dishes, sat on ordinary chairs and slept in a bed. He is surrounded with books, pictures, musical instruments,—in fact, at least in America, he lives like a prince. All at once he finds himself in a prison, stretched on a high cot of iron and enamel looking at a steel wardrobe, composition floor, grey paint, and much barrenness. Bells ring, signals flash, strange looking people come and go—but for the most part he is left like a man in a railway station, waiting. At certain set times he is washed, at others stuffed or starved, according to his notion of it. A written record is kept of his idleness, one cannot say of his activities, and so the days go by.

This is no criticism upon hospital management. Patients are indeed "cases." They must from the nature of things, be treated upon a more or less uniform system. They do not come to the hospital primarily to be amused.

Hospital design is studied to promote first of all, the cure of sick bodies. In so far as this is true, the modern hospital is a wonder. Labor saving appliances, sanitary methods, antiseptic provisions and systems calculated to be of the

greatest help to the greatest number are mutiplied beyond computation. It seems to me, however, there is danger of exaggeration of the mechanical and material side. There is sometimes, a little too much, the atmosphere of quantity production. Of course, that is the order of the day.

If only a hospital could be large enough, and command a sufficient clientele, one could imagine a well arranged plan whereby patients would enter, in a continuous stream to the sorting room, thence to the divesting room, the bath, the anesthetizing room, the cutting off room, the assembling room, the finishing room, the seasoning room, and finally to the shipping platform, from which they would be sent to all parts of the world.

Certain departments can, of course, be brought more or less up to this condition. Examination of the plans for the surgical building of a recent large hospital discovers a suggestion of it in the serried rows of operating rooms, one exactly like another, with standard sterilizing rooms attached, all of the same dimensions. It almost brought up the inquiry as to whether machines driven by electric or other power could not be employed to produce perfectly uniform operations. In this case patients could be wheeled in and out on schedule time.

No part of the hospital has been given more attention than the surgical floor. Whether each and every provision for antiseptic conditions has proved its worth I do not know, but some of them are probably more effective than others. Even here there is room for exaggeration, and, besides, the greater the complication the less assurance the operating surgeon has of the fact of absolute conditions.

All Wards Need Not be the Same

Looking about the institution one finds the surgical ward, adjacent to the operating rooms, the medical wards somewhat farther away, the contagious ward, and the ward for obstetrics. Whether a patient is held in the original ward, during his entire stay in the hospital, depends upon the system under which it is run. It may be that certain cases are transferred to a convalescent ward, from which they are discharged. Certainly all wards need not be the same as to appointments. While a contagious ward demands rigid antiseptic fixtures and surfaces such as may be swabbed with "germ killer" at regular intervals, it does not follow that a convalescent ward for non-infectious patients needs to be the same. Even at the worst, there is no requirement for dull grey or bristling white. Color by itself is neither septic or non-septic. No sort of material has in itself the quality of resistance to infection. The question is, how perfectly it may be disinfected. Certain deposits are harmful, others are not. After all, in most cases, it is a question of paint, in the first place, and cleaning afterward. The objection to metal is that it feels cold and looks hard. It is heavy, sharp as to corners and suggests severity. Wood is free from some of these qualities. In some cases a combination is desirable. Certainly to furnish a hospital on a single basis, set up as best for the worst conditions and good for all, is unscientific.

An instance of good judgment in the matter of finishing and furniture is the concession usually made to the children's ward. Pictures, color, and a certain mitigation of the rigid standards obtain in this part of the building. This may not be logical. The danger is just as acute in children's wards as in others; but it is good sense. Children are impressed favorably by pleasant rooms. Sometime it will occur to the minds of hospital directors that older persons are open to similar impressions. For example, suppose we should begin with the maternity ward. Here is a class of patients who are in reality not ill at all, in the strict meaning of the word, except for the occurrence of puerperal fever in some cases. Deadly germs are not thrown off as with diphtheria cases. There is less need for superanxiety as to danger of infection. It would seem that pleasant rooms, not entirely devoid of "dirt catching" objects could be permitted. The furniture should not be required to be "military." Pictures, curtains, ordinary easy chairs, reasonable rugs on hardwood floors should be admissible. In every way the experience in the hospital, for patients in this class, should be made pleasant. For some women the short period of convalescence partakes of a holiday. Freed for the moment from household cares and children they get a "good rest." Why not increase that impression?

Is It More Expensive?

But that sort of thing is expensive! It makes work. Where help is scarce it cannot be afforded. Very well, let us see. A regular hospital bed costs about as much as a hotel bed. A steel locker is as expensive as a wooden dresser. The easy chair —but there is no such thing as an easy hospital chair. The extra cost of the rug, perhaps a washable one, is conceded. As to the labor of keeping clean, what with the vacuum cleaner and the ordinary soft brush the room can be kept in condition. If it should become infected, by some curious falling out, disinfection is not impossible.

It may be that other sections of the hospital could be permitted a more or less similar alleviation. In any event even in the "ordinary wards"

any object of interest will beguile a weary hour, raise up a drooping spirit, or may be the cause of actual recuperation. A stencilled frieze on a painted wall or one printed on leather paper and varnished can add nothing to hazard, but on the other hand will be a relief to deadly monotony. The pleasant custom of bringing flowers to the hospital obtains in many places and is sometimes the regular business of young people's societies. I have seen such offerings crammed into an empty pickle bottle, instead of being set into a decent jar with some care in arrangement. Evidently their value in a therapeutic way is a good deal diminished. This may be no fault of the hospital staff, but it gives the appearance of casualness and indifference, which simply adds to the depression of hospital existence. But the staff has no time to fix flowers. They are hard working people, hurrying from one labor to another. Well, at least, if a proper container were supplied, the flowers would look better, and in many cases the patient might do the arranging.

Things of this kind, either in the furnishings or in the operation of a hospital, concern the matter of taking trouble. It is easier to get what is "standard" and to operate on routine. Moreover, "art things" are expensive. Worse than all they are likely to be bad art. As between a tawdry chair and a good one there may be no actual difference in cost. But the right things have never been brought to the attention of hospital directors. Advertisement is one of the best of educators. Why do not makers of real furniture sell to the hospital? Only because they have made no attempt to do so, leaving the field almost wholly to instrument makers, and the like. The consequence is that, outside of the offices, hospital furniture is inferior. It is not that furniture should be "fancy." Plainness is perfectly compatible with good style, as shown in a Windsor chair for example. Books, too, are possessed by hospitals. Some are worth while, but mainly they are the off scourings of the ephemeral trash brought in by patients and friends. At least that is what I am told by persons who know. Patients read these books from dire necessity of reading something. But there are many excellent books to be had, and that does not mean best sellers either. Why should not a hospital maintain a reasonable library of reasonable books, to be loaned to patients as needed? Occasional oversight of the book shelves would be required and could be made in many cases by the librarian of the city or town. A simple program for the use of the library would put the books to good use. In some hospitals a reading room for patients would be an excellent plan. The principal requirement would be the correct distribution and collection of books as compared with the lack of it in the present ordinary condition.

Bad Systems Should be Broken Down

Everything so far in this argument appears like an attempt to break down a carefully built system of safeguards in hospital management. Furniture, rugs, pictures, books, all potential carriers of disease, and all for the simple amusement of people who may, just as likely, be contented with things as they are now.

Well, part of that is well taken and part is not. Systems are and ought to be broken down whenever they become stereotyped. In regard to medical and surgical care, this is being done right along. But are hospitals so well secured after all? In a general way, yes. Is every place really sanitary? In particular, no. Every draft of air carries with it foreign material, which may contain the germs of disease. Until recently hospitals were not standard unless provided with fresh air forced through metal pipes, spreading from a general fan room. Some of the time the fans are operated. At other times they are not. The air, however, continues to flow, urged on by gravity and difference in temperature. In certain cases back drafts set up, carrying the air of one room to another. From what to what? Who knows? The exhalations of a patient may be gathered into a fresh air pipe, during one of the periods of non-operation of the fans, to be blown into an entirely different quarter as soon as they start again. In the curves of the pipe system dust collects, until by some freak of the air currents it is discharged in a cloud. This is no dream. I have seen it happen. And so fresh air ducts are not always fresh. Exhaust pipes are called foul air ducts. The name may be applied to both. They are not accessible and, if they were, they would never be cleaned. For this reason ventilation systems are not so popular as at one time and are in fact omitted from some modern hospitals, where the designers are going back to the simple expedient of the open window.

Present Equipment Not Faultless

Recently, also, some bright mind conceived the notion of hanging radiators on the walls, instead of standing them on legs, thus leaving the floor free for the oil mop. This would be an excellent expedient if the remedy were not worse than the disease. The floor is unobstructed, certainly, and can be mopped readily. Unhappily the wall brackets supporting the radiator catch more dirt than ever and the space back of the radiator, which was evidently overlooked anyway, cannot be cleaned at all.

I wonder if there are not other places equally

uncertain as to cleanliness. Experience eliminates many of these faults. The search after perfection however, is elusive. Accessibility is the great desideratum, and next to that, actual cleaning. It is agreed among authorities that prison walls though ever so high can always be scaled if they are unguarded, while at the same time very low walls, properly policed, are quite safe. The same thing applies to hospital security. If care is taken to clean efficiently and regularly, the danger of infection is so reduced that precautions against dirt catchers, so-called, may be relaxed, within reason. If cleaning is to be done anyway, the difference between absolute plainness and moderate freedom from it is negligible.

If it were not so we should all have been dead long ago. Hospitals are danger points, without doubt, but compared with street cars, public eating places, theaters, hotels, churches, and schools, they are lost in the running. The best protections to human life, today, appear to be fly screens, ordinary soap, and prohibition. These pertain to the home as well as to the hospital, and, with them, the danger from unsanitary surroundings —meaning our houses again—can be looked upon calmly.

It would be superficial to decry the greater part of the hospital sanitary systems. They are excellent. In some ways they may be exaggerated just as it is an exaggeration to forbid making currant wine at home. If so the medical profession will be quick to realize it and while making unremitting war on real dangers, will not be slow to take advantage of things that make for betterment, as well in the mental as in the physical surroundings of their patients.

THE KITCHEN OF MERCY HOSPITAL, PITTSBURGH

By RUSSELL H. WINDSOR, Ph.D., Pittsburgh, Pa.

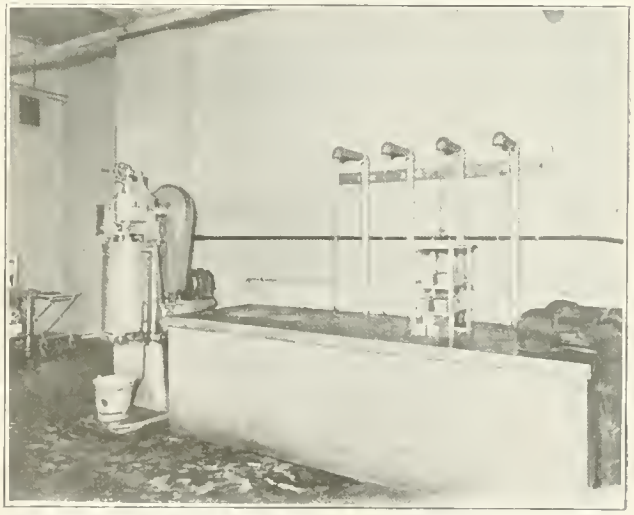
THAT the kitchen of an institution could so nearly represent a fairy tale of accomplishment, one cannot realize until one has visited the kitchen of the Mercy Hospital in Pittsburgh, Pa., and followed the course of the food from the delivery entrance through the various processes of storage, preparation, cooking, and final distribution to the patient, with the least expenditure of effort and time. In going through these bright, airy, odorless, and absolutely sanitary kitchens, one becomes conscious that here is the crystallization of some woman's dream.

That woman, Sister Innocent, the Sister Superior of the hospital, after thirty-four years association with the Mercy Hospital, came to know its needs. In addition to a knowledge of need, this good woman had also the vision of need supplied, and the executive ability to set into motion the forces to cause her dream to come true.

She very modestly disclaims credit, saying that all of her helpers and associates gave of their best efforts; no doubt they did, but she little realizes how much she stimulated those best efforts.

She was relieved for three years of the duties of superintendent of the hospital, which position she has held since 1909, and made building superintendent, but she has now resumed her superin-

1. Directly in front of the delivery entrance, and opposite the meat chopping room is the lift which brings the daily supplies to this daily supply and storage room. The shelves and cabinets of this room are all metal, mounted on a concrete and cement base, which eliminates the collection of dirt underneath.



2. The upright machine at the left is an ice cream freezer, which is cooled by circulating brine driven by an electric motor. To the right is the ice cream hardening cabinet. This is a steel tank, insulated with sheet cork, and finished outside with cement, through which go coils submerged in still brine and filled with ammonia.

tendency. Her ability to cope with situations is revealed in a little circumstance, when because the workmen in installing the refrigerating system put in some cement work, the bricklayers thought their rights had been infringed upon and were going to quit the job until that cement was torn up and they were allowed to put it in. Sister Innocent stood in the entrance as they came down off the job, talked to them, refusing absolutely to let them leave, finally persuading them to go back to work—and the strike was settled.

3. The bake shop has outside light and ventilation, white tile walls, and red tile floors. At the left may be seen the three-deck oven heated with natural gas. Next comes a steel jacketed kettle, then the flour bin with the elevator which brings the flour up and over and sifts it into the dough mixer. The machine at the right is the cake mixer.

Sister Innocent very naïvely remarked to me that she just told Mr. Stotz, the architect, and Mr. Gloekler, who installed the machinery in the kitchen, just what she wanted, and they were so very capable that they worked it out. She did not seem to realize, as I am sure those gentlemen have, that a great deal of the final success was due to the fact that she did know definitely just what the need was.

The kitchen is located on the third floor of the new annex, but on account of the grades opens directly on the yard at the delivery entrance. All supplies are received here, and distributed to their respective places with the least effort. Just to the right of the entrance are located the various compartments of the refrigerating system, five in number. First is the meat compartment. An overhead rail with hooks attached to wheels which roll along the rail, and which extends from the refrigerator out to the door where a truck backs up to be unloaded, enables a whole carcass to be fastened on a hook while on the truck and then rolled along without unnecessary handling. With this overhead rail is also connected an overhead scales so that the meat is weighed as received, and while in transit to the refrigerator. This rail also passes by the cutting blocks, so that when, in the butcher's parlance, the carcass is ready to "be broke up," it is rolled out to the block and such part as is wanted is taken off on to the block for further cutting. All the meat racks are of steel dipped in heavy block tin.

Just to the left of the chopping block is the silent chopper for meats or vegetables, and back of that a combination grinder, one side being used for coffee providing fresh coffee for each meal, the other side being a meat chopper. Both of these machines are motor driven. Conveniently located just back of the chopping blocks are the sinks for washing and cleaning the meat.

This meat department has several very large windows opening out on the yard giving natural light and outside ventilation. It is entirely isolated from the rest of the culinary department, though easily accessible.

Next to the meat refrigerator comes one each for sea foods, dairy products, fruits and vegetables. These refrigerators are all lined with white glazed tile, and the refrigerating pipes are exposed to give free and easy access to them. They are also piped so that one compartment may be operated independently of the other, thus effecting a saving. All the refrigerators throughout the hospital are cooled by this system, which also furnishes twenty-four tons of ice daily.

Passing from the refrigerating room one comes into the vegetable preparing room with its large

4. This view of the meat chopping room shows the chopping blocks, and to the left, the silent chopper for meats and vegetables. Back of that may be seen the electrically run coffee grinder. The sinks for washing and cleaning the meat are conveniently located just back of the blocks.

sinks of steel with welded joints, long steel top tables with welded joints, and steel shelving. In this room are a vegetable peeler, motor driven, and a vegetable cutter. On one of the tables is fastened a can opener. There are two steam jacketed kettles used for grease.

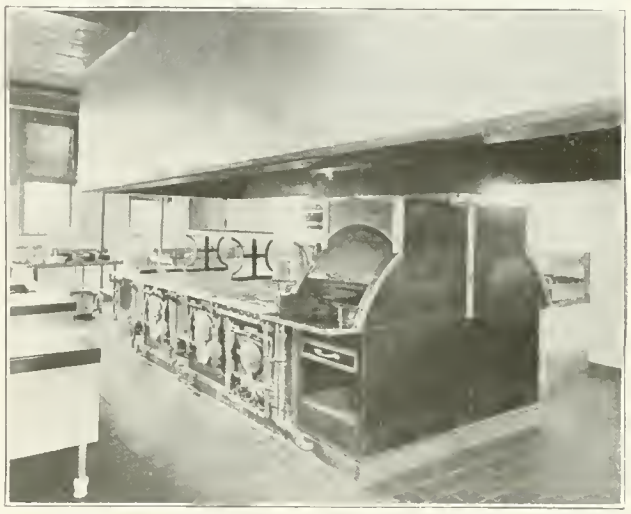
Just opposite this room and directly in front of the delivery entrance is the lift which takes all stock supplies to the storage rooms in the basement, from whence the daily supplies are brought to the daily store room for package goods (Fig. 1.) This room is furnished with all metal cabinets and shelving mounted on a concrete and cement base which makes for easy cleaning, and eliminates the collection of dust and filth underneath the cabinets. With the exception of the enclosed steel cabinets which are set to the plaster so closely as to preclude the possibility, all of the shelves are free-standing, making them vermin and rodent free. This room also has natural light and outside ventilation.

In Fig. 2, the upright machine is an ice cream freezer, which is cooled by circulating brine driven by electric motor. In this machine the cylinders are made of nickel silver, and it gives a large yield of nice smooth cream. At a conservative estimate it yields ten gallons of ice cream from six gallons of cream.

To the right of the freezer is the ice cream hardening cabinet. This is a tank made of boiler plate steel, heavily insulated with sheet cork, and finished outside with cement. In the tank submerged in still brine are the coils through which ammonia is expanded, giving a temperature of from 4 to 6 degrees above zero. There are two spaces for storing ice cream in ten gallon cans, and four cages for hardening cream for large bricks so that it can be taken out and quickly sliced for serving, making for clean handling. This latter was one of the ideas of Sister Innocent which was worked out for her.

5. At the last minute after the truck is loaded it passes the toaster for hot toast.

At the extreme left of this picture can be seen a part of the electric bread slicing machine. At first there was provision for a hand power bread slicer, at sight of which Mr. Gloeckler said to Sister Innocent, "Is that machine for the nurses home?" She looked a little surprised and asked "Why?" He replied that it seemed so small and inefficient for the work it was expected to do, whereupon Sister asked him if he had anything better, and he told her that he had a power machine that he would install free on ten days trial and then if she didn't like it he would take it out. The result was that that machine has been in use three times a day every day since, and to see the perfectly evenly sliced bread that it turns out, requiring only that the loaves be placed in the carrier, would be a joy to the heart of any housekeeper. Because in hurry and excitement many people take unnecessary risks, and to protect their fingers, Sister Innocent had an addition of a galvanized iron hood built in front of the knives so that the attendants in grabbing for the slices of bread could not reach back to the knives but must wait until they were pushed out beyond the hood. Just in front of this machine is a large galvanized iron bread box with cover, where unused, unbroken slices of bread are placed to be used for toast.



6. The diet kitchen has a complete set of four ranges with a separate broiler or toaster at one end, also a complete set of waffle irons and griddles.

Fig. 3 shows the bake shop with its daylight, outside ventilation, white tile walls, and red tile floors. At the left is the three deck oven, heated

7. The diet kitchen and general kitchen have sets of ranges exactly alike and backing up to each other as shown in this picture. The canopy which is ten feet wide and thirty-four feet long, is vented and connected with the mechanical ventilating system so that all odors are carried out, leaving the kitchen free from odors and smoke.

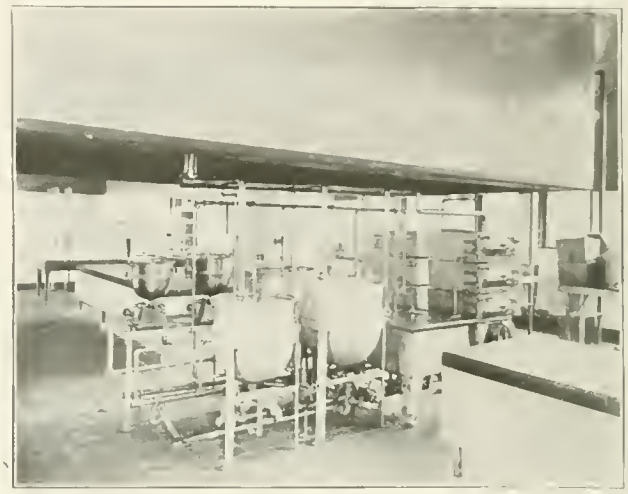
with natural gas. Next to the oven is seen an aluminum steam jacket kettle for cooking custards and pie fillings. Next to the far wall is the flour bin, with the elevator which brings the flour up and over and sifts it into the dough mixer. At the right is seen the cake mixer which is also used for pies and for mashing potatoes. Sister Innocent says they could not keep house without this machine. In the doorway is seen the rack for cooling pans of rolls, pies, cakes, etc.

Besides the machines shown in the picture, the bake shop contains tables and all-steel cabinets, many drawers and bins; also a large refrigerator in which to keep custards, eggs, butter, lard, etc., used in the making of pastries and cakes.

In Fig. 6 we see the ranges for the diet kitchen, a complete set of four with a separate boiler or toaster at one end; also a complete set of waffle irons and griddles. Backing up to and joining this set of ranges we see an exact duplicate set for the general kitchen. The diet kitchen has all of its equipment complete and separate and it is duplicated in all particulars in the general kitchen. The view in Fig. 7 gives a pretty good idea of the double arrangement all placed under the huge canopy ten feet wide and thirty-four feet long, finished in plaster outside and inside, the inside plaster being specially treated for fire resisting qualities. In addition to this there is a steam pipe, shown in front, so arranged that should a collection of grease in the canopy take fire, live steam can be turned on it by opening a valve below which will smother it out immediately. The canopy is vented and connected to the mechanical ventilating system of the building so that all odors are carried out, leaving the kitchens absolutely free from odor and smoke.

The ranges are mounted on a cement base finished with tile cove (rounded corners), with all pipes concealed except at the points of necessary connections. Overhead smoke pipes are eliminated altogether. These are features which any housewife would appreciate, for one not familiar with the facts could scarcely imagine the amount of labor it takes to keep the pipes around a range free from the accumulation of grease and dust, and at all times they are unsightly. The ranges are combination heated by either gas or coal.

The diet and general kitchen each has its own separate refrigerator, steel top work tables, steel



8. The diet kitchen has a steam table, a three section compartment for meats or vegetables, two copper, steam jacket kettles, and an aluminum kettle for soups. The tile floor is depressed under the kettles to carry off any overflow. This scheme, which was an idea of the architect's, has been found to work so admirably that the hospital strongly recommends its general adoption.

sinks for general work. Each side has a deep steel pot sink with welded corners, at the bottom of which is a steam pipe with muffler, to keep the water hot for constant use; this prevents waste of soap, because a big sink full of good strong soap suds can be used for a number of pots if it is hot, whereas if it is allowed to get cold it will not clean greasy kettles. Then in addition each side has a hand lavatory located against a pillar in the immediate center of surrounding ranges, work tables, sinks, etc., for the use of the cooks and helpers.

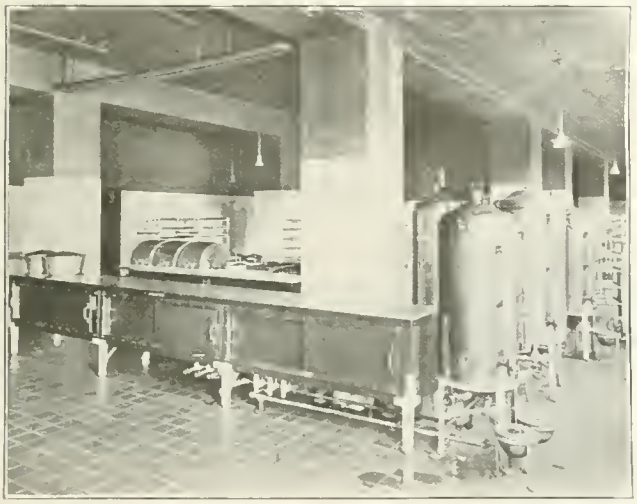
The diet kitchen has a steam table for keeping food warm; two copper steam jacket tilting kettles for making custards or boiling milk. These are seen to the left of Fig. 8, also an aluminum steam kettle for soups, an open type vegetable steamer, the pans for which may be seen piled upon a table at the extreme right of Fig. 8. It has a three-section compartment steamer for meats or vegetables.

The general kitchen has two aluminum steam stock or soup kettles, an open type vegetable steamer and a three-compartment meat or vegetable steamer. These compartment steamers

work on the same principle as what are known as pressure cookers in the home.

In Fig. 8 may be seen an achievement of the architect. Under the steam kettles instead of a pan or depression to catch any overflow, as is usually seen, and which is always greasy and unsightly, Mr. Stotz worked out a simple plan of depressing the tile floor from all directions leading to the cesspool trap which is shown to the left of the kettles. Many were skeptical as to the practicability of the plan but it has worked so well that one wonders why no one ever thought of it before. It is easily cleaned by means of hose and mop and is really sanitary. Draining into the trap are the two pipes leading from the kettles to carry off the water with which they are cleaned, and above are seen the pipes, the smaller of which is placed below the steam pipe and connected with it for draining off any condensation so that no water may drain back into the kettles. In front of the big kettles are the large faucets by means of which the soup is drawn off for serving.

The general kitchen also has a steam table for keeping food warm, all the steam tables having



9. The food is transferred from the kitchen to the steam tables of the service room, from which it goes to the serving tables, and thence to the trays.

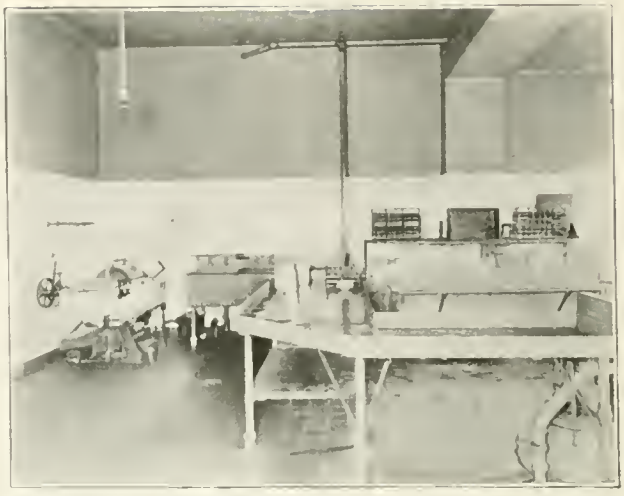
solid nickel silver tops, solid nickel silver covers for vessels, also nickel silver trays. Fig. 8 also shows in the foreground and one in the background, the service tables made of No. 12 gauge steel, highly polished with turned edges over sides of enameled porcelain. They have welded bases made up of steel pipe heavily tinned and porcelain enamel bases around the foot of the legs. Another excellent feature of these kitchens is that they have plenty of tables placed where they are needed.

In the service room the food that is prepared in the kitchen is transferred to the steam tables made of planished steel with tops and legs of porcelain enamel; one is shown in Fig. 9, between the pillars and back of the hot serving table in front, which has a polished steel top with steam coils directly underneath and dish warming ovens below. The servers stand behind the hot serving table, take the hot dishes from the ovens below, dish the hot food from the various vessels in the steam table and set them on the serving table where they are kept hot until transferred to the trays on the trucks which are rolled between the hot and cold tables, one of which is this way from the hot table but not shown in Fig. 9. There are two groups of hot and cold tables; the arrangement is better shown in Fig. 10, where one of the cold tables is just in front of the refrigerator, both of which are made of solid oak, insulated with sheet cork, lined with white opalite glass and cooled by mechanical refrigeration. The table is accessible from both sides by doors which slide and are out of the way when open, and there are compartments for cooling dishes as well as food. The tops of the cold tables are marble, two inches thick and dished in the center. Here the servers take the chilled dishes, serve the cold foods directly from the refrigerators, place them upon the cold top tables from which they are put on the trays on the trucks at the same time the hot foods are put on from the other side; thus a truck containing fourteen trays may be loaded in a few seconds' time.

Just at the end of the serving tables and easily accessible are the coffee and tea urns of the combination boiler and urn type. There are two thirty-gallon coffee urns and two twenty-gallon tea urns (see Fig. 9). At the last minute after the truck is loaded it passes the toaster, Fig. 5, for fresh hot toast.

10. There are two groups of hot and cold tables in the service room. Just at the end of the serving tables and easily accessible are the coffee and tea urns, two thirty-gallon coffee urns, and two twenty-gallon tea urns.

11. An unusual and interesting feature of this hospital is the self-service equipment for the belated doctor, a service which he greatly appreciates. There is a combination warming cabinet and steam table to keep hot food hot, a glass lined refrigerator to keep cold food cold, and a coffee urn.



13. The dish washing machine is of the two-tank type, with the baskets of dishes drawn through on an endless chain. They are first sprayed with hot, soapy water, then with clear hot water, finally with boiling water for sterilization. When they come out from the machine they are shoved along on the metal table to cool and dry.

When a truck is loaded it is taken without delay to one of the six automatic dumb waiters to be sent to one of the upper floors for distribution. The trucks are shown to the left of Fig 10, the first one showing the tag with the destination of that particular truck. A dumb-waiter is in fact a small automatic elevator, just large enough to admit one truck. There is a locking device to prevent the truck from moving, and until this is in place and the door closed the car cannot be started. Then a button is pressed, indicating the desired floor and the car is raised or lowered automatically. Until the car stops it is impossible to open the door to remove the truck. A light and buzzer signals the arrival of the car on that floor, attracting the attention of the nurse on the floor, whereupon she rolls the truck along and rapidly distributes the meals to the patients, so that the hot food remains hot, and the cold food cold, until the patient can enjoy it.

The day I visited the hospital I planned to be there around five o'clock in order that I might see the dishing up and serving of supper, which I knew occurred at that time. Sister Innocent and I started from the office at ten minutes to five. We encountered a delay at the elevator that was to take us to the third floor, and I rather wondered at the nervousness displayed by the Sister, for I supposed supper would be running on till well after six at least, as they had 535 patients in the hospital that day. Finally the elevator came and the sister had the man take us to the third floor immediately without taking time to stop for the passengers on the second. We made straight for the service room and when we got there I found only three or four trucks left to be filled, and they disappeared so rapidly that I scarcely had time to get my eyes focused on them. I looked at my watch and it was five minutes after five. Sister Innocent asked the head of the department at what time they had started serving and she said at the usual time, ten minutes to five. In fifteen minutes they had dished, served, and distributed more than five hundred trays! Sister Innocent says that the only delay there ever is, is caused by the fact that sometimes the nurse on the floor cannot remove the truck promptly on arrival.

12. At the right is the door from the dumb-waiter, opening into the diet kitchen of each floor, which is equipped with a combination hot plate and broiler for emergency use at night.

Fig. 12 shows, at the right, the door from the dumb-waiter, which opens into the diet kitchen. At the left is the door into the corridor. On each floor

there is a diet kitchen equipped with a combination hot plate and broiler for emergency use at night (center Fig. 12). Each diet kitchen also contains a steel table, a porcelain enamel storage cabinet, porcelain enamel sink and glass lined refrigerator. In these emergency diet kitchens there is a ventilating shaft above the hotplate, the walls are white tile and the floors are red tile.

The nurses' dining room is on the same floor as the general kitchen and the nurses are served by means of trays on trucks.

The doctors' dining room is also on the same floor as the general kitchen and served in the same manner as the nurses', for those who are there at the meal hour. For the benefit of the belated doctor, the dining room is equipped with a self service feature composed of a nickel silver, porcelain enamel, steel warming cabinet and combination steam table, urn stand and coffee urn, and a glass lined refrigerator, shown in Fig. 11.

The Washing of Many Dishes

On one of my visits I watched with a great deal of interest the accomplishment of that dreaded task of many households, the washing of many dishes. In Fig. 13, the arrangement is shown. To the left just out of the picture are the dumbwaiters, and as the trucks are returned they are brought over to the large scrap table in the foreground. As the trays are taken off any food that is available for use is taken off and placed on a table for that especial purpose to the right, then the dishes are scraped and sorted and packed into special baskets and started through the machine; one being just ready to start at the right of the piles of saucers at the end of the table. This machine is the two tank type and the baskets of dishes are drawn through on an endless chain. In the first tank at the left, the basket of dishes automatically stops until thoroughly cleansed of grease or food under a spray of hot water which is forced through a receptacle holding soap, then it moves into the second tank where it again stops under a spray of clear hot water for rinsing, and finally at the time of leaving the machine it passes under an automatic spray of boiling water for sterilization. As the baskets are ejected from the machine, which is motor driven, they are shoved along the metal table and left to cool and dry without the necessity of wiping or handling. There is a separate department with all metal tables and sinks for washing glassware.

At the left of the picture is shown the motor driven silver burnishing machine of the two cylinder or drum type, and conveniently placed is the sink for silverware.

The sisters' refectory on the fifth floor is served from the main kitchen by means of a dumb-waiter.

The food from the time of its delivery at the entrance is kept moving in one general direction, and is not carried back and forth. Thus unnecessary effort is eliminated. All goods are delivered into the receiving room, the meats going directly into the cold storage by means of the overhead rail and scale as indicated. Other things are weighed as received on the scale in the receiving room and then distributed either into cold storage or by means of the lift to general storage in the basement, from whence the daily supplies are brought to the kitchen storeroom. The preparation room is conveniently located to receive the foods from storage, then taken into the bake shop or kitchens. From there they move on into the service room, thence to the food elevators. The dishes come back by way of the elevators to the dishwashing department immediately in front of them, to be washed and placed ready for the next meal.

I have been through the kitchens of many homes, hospitals, and institutions of various sorts, but never have I seen one so completely equipped with machinery or so perfectly adapted to its uses as is the new kitchen of the Mercy Hospital.

CINCINNATI HEALTH EXPOSITION HOLDS FORTH MANY ATTRACTIONS

The Cincinnati Health Exposition to be held in Music Hall, Cincinnati, Ohio, October 15 to 22, brings back, according to the *Weekly Bulletin* of that city's department of health, memories of the great World's Fairs of the past, linking their accomplishments with the wonderful progress in the industrial and scientific world since their time.

One of the main features of the exposition is to be Rural Sanitation Day, which is to have a program of vital interest to farmers and their families. The lectures are arranged to show in a simple and comprehensive way how the farmer can best safeguard his own and his family's health, and they are based on the results of years of investigation by officials of the United States Public Health Service and other organizations. One of the principal speakers on this day will be Dr. C. L. Lumsden of the United States Public Health Service. There will be many interesting and unique features at the convention, among them a wrecked automobile, showing how motor accidents are caused and how they can be prevented, which will be displayed by the Chamber of Commerce; the complete equipment of a school physician's office, with a doctor and nurse in attendance to examine children at the exposition; and in addition to the educational exhibits there will be 150 commercial displays, which will have a distinct bearing on health matters.

The array of nationally known speakers in the health field, including Dr. Royal S. Copeland, health commissioner of New York City; Dr. Frankwood E. Williams, of the National Committee on Mental Hygiene, and many others, the interesting program and the educational moving pictures, pageants and displays, will make this week a notable one, and of decided interest to anyone in the health field.

THE DOCTOR AND THE COMMUNITY HOSPITAL

By E. E. BAMFORD, M.D., Bamford Clinic, Centerville, Iowa

It is time that the doctor had as favorable conditions under which to work as the surgeon has had. The development of aseptic technique has revolutionized surgery, and also advanced internal medicine, but at the same time has caused physicians to consider the patient from a pathological standpoint rather than as an individual. However, the recent awakening to the importance of cell chemistry promises to affect internal medicine much as surgical asepsis did surgery. In view of this revival adequate facilities must be provided for the rural community doctor, who has been seriously handicapped in the past. The small community hospital is surely the logical place for this doctor to do his work.

INTEREST in the community hospital movement is growing in many sections of the country. A number of such hospitals have been installed in the last few years and are proving most satisfactory. As in other enterprises, the service in the beginning will scarcely reach 100 per cent efficiency, as compared with the leading hospitals of today, yet it is to be remembered that the service in all hospitals is undergoing changes as the institution keeps pace with medical progress.

The doctors serving rural communities have been compelled to work under a heavy handicap as compared with their brother physicians who have had the advantages of hospital facilities. Patients whom they recognize as being in need of hospital service, without consideration of the business sacrifice it entails, are promptly advised accordingly, and they not only cease to treat the case, but lose their opportunity to closely follow it up, and with it their greatest chance to develop professional efficiency. After repetitions of this kind, the people are apt not to wait until advised to do so, but, of their own accord leave their physician and consult the hospital doctor, because honest loyalty shown by him has led them to consider the hospital doctor as of superior quality, and to minimize the efficiency of the home doctor.

Small Town Hospitals of Recent Growth

Only a few decades ago, such a thing as a small town hospital was not thought of, and hospitals were found only in centers of larger population, or where the teaching of medicine was conducted. Here medical men journeyed to acquaint themselves with the applications of advanced and better methods, and observing the many advantages, both doctor and patient recognized the urgent need of the local hospital.

Except in the larger cities, the hospitals are deriving the greater per cent of their patients from the rural districts, and when the capacity in one building has been reached, additions are added, or other hospitals are built. This is constantly observed in all the medical centers, and is not governed by the growth of the center it serves, indicating that the rural districts are the fields looked to for hospital patronage.

Among the many advantages of having a hospital nearby should be mentioned the avoidance of inconvenience and risk entailed in transporting the sick a considerable distance to a hospital. It is also inconvenient and expensive to have to carry the sick long distances. Above all, if the hospital is near the physician can conduct the case, and he does not lose the opportunities for professional development as he otherwise would, if, at the moment of critical illness, he were compelled to turn the case over from lack of facilities.

As it stands at present, almost every patient seeking the physician's advice will require some form of laboratory study or test, many of which cannot properly be carried out except in an institution especially equipped for the work.

The profession is anxious to give its patients the service that is due them; both patient and doctor realize that such a service cannot be fully carried out without facilities created for that purpose.

Public Demands Good Service

The public mind, in recent years, has become alert and exacting concerning the care of the sick, and will not be satisfied with a mediocre quality of service from the physician, so that the recognized need of better service in rural areas has passed beyond the individual stage and has become a public demand. For this reason, if for no other, the physicians who represent community areas must align themselves with this movement or risk a loss in a business and professional way.

The humanitarian instinct which prompts such movements can be heartily commended. None can regard the promotion as a selfish enterprise, for the hospital, as a financial proposition, will not be viewed with envy by those who have borne the burden of sustaining it. The same fine feeling

which prompts its existence in the city, argues for its establishment in local communities.

The public is observant of the advantages it brings in the care of the sick where an up-to-date, though small, hospital is located. When public feeling reaches this point, it will act in its own interest if shown that the benefaction is so organized as to give promise of perpetuation. Hospital success means hospital perpetuation, and it depends wholly on the interest given to the institution and the quality of work done by the staff who direct its management.

In all fields of human endeavor, it is the man up on his toes who accomplishes things. Aggressive men realized that many of the important methods now used in diagnosis and treatment could not be made available to patients without hospital facilities.

Group Service Supplanting Individual

Physicians realize that the development of medical science is now so broad that the individual working alone cannot render a full service to his patients. Though a man possessed a full knowledge in all the lines, he would not have time enough to apply the important details. For this reason, his work is becoming a group service instead of individual, as it has been in the past, the aggregate work of the group representing the one-man work of the past. This kind of service cannot be efficiently rendered without a center for the group to work from, and this center is logically the hospital.

As an illustration of the importance of such a center, we could mention prophylactic medicine, which is daily becoming more popular. Certain features of its application require the facilities of a modern hospital. Cases requiring intravenous medication, spinal puncture work, urethral examination and medication, blood transfusion, and many other important therapeutic measures are all, essentially, hospital services.

Owing to the customs and methods of medical practice in the past, the doctor, as he faces the present situation, finds that a great upheaval is taking place in the application of his professional services. It is a change, the result of scientific advancement. The public are convinced of its advantages and are demanding it. These points are proven by observing the vast number of ailing people who travel long distances to avail themselves of medical advantages not offered in their localities.

Recognizing these things, the doctor should be alert to align himself and his efforts with this movement requiring a higher professional service. He will discard nothing of value from the past, but must be in a position to apply the proven advantages of the present.

This demand, though new, is not spurious. Rooted in scientific discoveries representing fifty years of the greatest achievements known to the medical world, it will not recede.

Internal Medicine Greatly Advanced

In the last twenty-five years, internal medicine has not received the consideration to which its importance entitles it. Aseptic technique has made surgery a spectacular art. It has given us our knowledge of pathological processes in the living body, and this has added much to the sum total of knowledge in all diseased conditions, greatly advancing internal medicine.

But at the same time, it has had a tendency to cause the physician to consider the patient from a pathological standpoint, losing sight of him as representing an individual equation to be so considered and so studied, regardless of what pathology is known to exist. Our literature teems with records of vast numbers of patients classified according to the organic pathology they present, with usually the same treatment for all, and with far too little consideration of the case as an individual entity.

This state of things has had a bad effect on internal medicine, and has tended to fix the public eye on the surgeon and his work, at the same time minimizing the work of the internist. As a result, it has created the impression that hospitals are only essential for surgical work. As it now stands, the majority of people make an undue distinction between the internist and the surgeon. Both the surgeon and internist know that this distinction in the work of those treating human ills should not be made for the reason that one is equally as important as the other, and that it should be viewed as group work, every branch of which is equally important.

Surgery, in the ages to follow, will doubtless stand as man's greatest achievement in scientific art. Yet the great minds which have brought surgery to its distinguished place could never have done so had it not been for the helpful facilities with which they were surrounded.

This advantage, which the surgeon holds, leads him to call out to the internist for earlier and more correct diagnoses, seeming to forget that the quality of a man's work often depends on the quality of his tools.

But today everything indicative points to a keen revival of interest in internal medicine.

The recent awakening of the profession to the vital importance of cell chemistry as it occurs in the body, promises to affect internal medicine

much as surgical asepsis did surgery. At this time the observations concerning endocrine gland secretions and their influence on body and mind development and also on body function throughout life are creating new and broader interest in internal medicine. Internal medicine is coming into its own. The internist is clearly right when he insists on having in his work an equipment for serving his patients as well suited to their needs as the surgeon requires for his. To render this class of service, he must have as good a chance in the way of equipment as the surgeon has demanded and received from the public for his work.

There can be but one correct motto in hospital service: that is, "The Patient's Welfare First." In carrying out such a service, full team-work on the part of the management and staff is indispensable. Naturally the management will look to the staff for the establishment of those features which make a hospital what it is intended to be. Really, the management is helpless if the staff does not cooperate whole-heartedly. This puts it up to the physicians using a hospital as to what grade of efficiency it will attain. Consequently, if the profession in any locality will have these advantages, let them expect to give liberally of their time and talents, if they would see it succeed.

HOSPITAL LAUNDRY SHOULD KNOW COSTS*

By WALTER TRIMBLE, Chicago, Ill.

I NOTED with interest in a recent number of The Modern Hospital that plans are being made to devise a uniform cost finding system for hospitals, with the object of securing its general adoption. Various industries have done this with great profit—and, after all, is not a hospital a vital industry? Whether it is or is not, it is similar to industry in one thing: it must be efficient and economical. Hence, we must remember that cost finding is the first step toward efficiency and economy, and act accordingly.

It is to be hoped that the sponsors of the hospital cost finding system will meet with a prompt and hearty response from every hospital manager, whether the institution be a large or a small one. And it is further to be hoped that the hospital cost finding system will include the laundry department.

I know from observation that there is a great variation in the costs of production in hospital laundries, and this clearly shows that in many cases a material saving could be effected. Under present conditions, the manager of one hospital cannot compare his laundry department's cost of production with that of several other hospitals, because cost accounts seldom are kept, and if they are kept at all, they are not compiled on the same basis and in the same manner.

It has been demonstrated in the commercial laundries that a uniform cost finding system is entirely practical, easy to keep, inexpensive and of great advantage. Many members of the Laundryowners' National Association have used that organization's uniform cost finding system for several years, to their great profit. It seems that this system easily could be modified to meet the needs of the hospital laundries, should they prove to be different from the needs of the commercial laundries. At most, this will only involve a few minor details.

The hospital laundry manager (and, I would add, also the hospital manager) who has no cost finding system to guide him may be likened to the captain of a ship who has no compass with which to regulate his course. He can keep going, it is true, but he does not know whether he is going the most direct way, and he does not even know whether he is going a safe way.

As a business proposition, it pays to give the manager of a hospital laundry an object at which to aim, through putting him in competition with the managers of other hospital laundries. If one manager of a hospital laundry should find, through the means of comparing his costs with

*This is the eleventh of a series of articles by Mr. Trimble on the hospital laundry, which is appearing in The Modern Hospital.

A MODEL IRONING DEPARTMENT

A section of the ironing department of the laundry of St. Mary's Hospital, Milwaukee, is shown in this illustration. The large hood above the flat work ironer carries away all of the heated and humid air, a large volume of which comes from this machine. An out-going current is created by an exhaust fan.

those of several others, that his cost of production was too high, he would be sure to take steps to correct his methods. Besides this, if there were a uniform cost finding system in general use, the manager of a hospital would have a means of checking up his laundry department and finding whether it is as efficient as it should be.

Keep Other Accounts

It seems to me that the hospitals should go even a step further than the adoption of a uniform cost finding system and adopt a uniform accounting system, at least as far as their laundry departments are concerned. A hospital's laundry department should be credited at fair commercial rates for the work it does, and it should be charged with the money paid out for it, as well as for rental, power, light, heat, water, electricity, interest on investment, depreciation and so forth. Then it should be credited with the profit that is shown. In case it shows a loss, something is radically wrong, and steps should be taken to set matters right.

All of this bookkeeping will take a little time and it will involve a little expense, it is true; but the economies that will be directly and indirectly brought about will offset this time and expense many times over. As things are now conducted in many hospital laundries, no money value is placed on the service of the department. The articles sent to the laundry are just washed and returned, no account being kept of the pounds of goods, number of pieces, or value of the work done.

Often, in such cases as the foregoing, unnecessary workers are carried on the pay-roll when the hospital is not filled with patients, and nobody is the wiser. Thus, at such times, while the hospital's receipts are at the low-water mark, the laundry's pay-roll remains at the high-water mark. This one thing, taken alone, shows the necessity of putting in a complete accounting system that will credit the laundry department with what it does and charge it with what it gets, just as though it were an outside concern.

Modern Ways

Many old and inefficient machines are still in use in hospital laundries, and likewise many obsolete methods are still found in practice. If there were a standard cost finding system in general use, a checking up of costs would soon call attention to these. If the manager of a hospital should find that it costs considerably more to wash a hundred pounds of flat work in his laundry than it does in another in the same city, he would be very apt to look into the matter. And this is what a uniform cost finding system, if carefully kept, would show in more than a few cases.

A WELL-EQUIPPED WASHROOM

The washroom of the laundry of St. Mary's Hospital, Milwaukee, is amply equipped for the volume of work it has to handle, having two large metallic washers, a small wooden washer and a high-speed extractor.

The costs of production may differ on account of such a large number of causes that it is not expedient to point them out at this time; but none of these causes is hard to find through an analysis of conditions in a laundry. One should not, however, compare his costs with the costs of a laundry that is operating in some other city, where wages and other items of expense are different, without making due allowance for the variations.

Will You Change Old Methods for New?

The manager of a hospital may not be in position to scrap his old machinery and buy new, and this may be a handicap that the laundry manager cannot overcome. But perhaps he is not doing the best that can be done with the means at his command. Few men are doing so well that they cannot do at least a little better, and all can try.

Men will, as a rule, change old machinery for new with good grace, but for some reason most men are reluctant to change old methods for new ones. Therefore, if a checking up of costs shows that the methods in the laundry department are wrong, the hospital manager may find it hard to get the head of his laundry department to make the necessary changes. If you cannot get a man to change from wrong to right, it is manifest that you are employing the wrong man.

BILL PROVIDES FOR FAMINE SUFFERERS

A resolution has been introduced into Congress by Senator King of Utah, authorizing the President to use army medical supplies for the relief of famine sufferers in Russia. Surplus medicines, drugs, and medical supplies of the army, up to the value of $5,000,000 will be placed at the disposal of the sick and suffering people of Russia

MEDICAL AND HOSPITAL CARE OF BENEFICIARIES OF THE UNITED STATES VETERANS' BUREAU

CONDENSED SUMMARY OF AN ADDRESS DELIVERED SEPTEMBER 14, 1921 BEFORE THE AMERICAN HOSPITAL ASSOCIATION, AT WEST BADEN, IND., BY HAVEN EMERSON, M.D., OF NEW YORK CITY*

IN ITS simplest terms, the original War Risk Insurance Act of October, 1917, and the various amendments, including the latest one, signed by the President on August 9, 1921, creating the Veterans' Bureau to administer all the benefits provided by the Federal Government for men and women who served in the military or naval forces of the United States during the World War and were separated from service under honorable conditions, in addition to providing for various forms of United States Government insurance, call for the payment of compensation and the furnishing of such reasonable governmental medical, surgical, and hospital services and supplies, including prosthetic appliances, as may be useful and necessary.

Although I am certain that I could count upon your interest in any or all phases of the government's undertaking to do an intelligent piece of medical and educational reconstruction work for the ex-service men and women of the World War, I shall confine myself chiefly to those features which bear upon the claimants as patients, the provision for the medical treatment at present, the plans for further development of medical services and such matters of rating disabilities for compensation purposes as have a bearing upon the medical work of the Bureau.

Those Eligible for Medical Care

Those who are eligible for medical care and treatment are primarily the claimants who have been found to be suffering from a disability of service origin which is of more than 10 per cent degree. The trainees of the former Rehabilitation Division of the Federal Board for Vocational Education, now the Rehabilitation Division of the Veterans' Bureau, are also entitled to medical care and treatment for any disabilities which interfere with the prosecution of their vocational training, whether or not such disabilities are of service origin or are due to their own willful misconduct or are intercurrent or accidental diseases and injuries.

There will appear in the future a large class of patients, it is believed by Dr. Emerson, who have not before been entitled to treatment: (1) Those who have disabilities less than 10 per cent who now, according to the Sweet Act will receive treatment. (2) Large numbers who have not applied for compensation before, but who under the new provisions of the law will ask for medical care. All persons honorably discharged from the army in need of emergency care, though their claims have not yet been determined, will promptly receive such care from the Bureau.

It is not intended or provided by the law that all and sundry ailments of any discharged soldier, sailor, or marine, regardless of service origin or aggravation, shall receive medical care and treatment, but only those diseases or injuries due to service shall be treated, whether they are of 10 per cent degree of disability or less; and where the disability is more than 10 per cent, in addition to medical care and treatment, the compensation in proportion to the degree of reduction in earning capacity provided by Section 302 is payable.

Conditions Under Which Payment Is Made

Payment by the Veterans' Bureau for treatment of service-incurred disease or injury in those subsequently found to be eligible for compensation and medical care and treatment by the Government, may be made if it is shown that the claimant was not at the time aware of his rights and privileges under the law, or found himself in such place or condition that he could not avail himself of authorized government services even if he did know he had a right to them.

According to the weekly report of hospital service as of August 18, there were 18,527 patients in government hospitals and 9,490 patients in hospitals under contract with the government, making a total of 28,017 patients in hospitals.

There were ninety-three government hospitals in use and approximately 800 contract hospitals, showing, therefore, an average of 199 patients per hospital in government, and twelve, approximately, per hospital in contract hospitals.

There were 5,826 vacant beds in government hospitals. The Bureau has contracts with 1,590 hospitals.

At no time during the past year and more has there been any shortage of beds in government hospitals for general medical and surgical patients, and the same may be said for the past six months with regard to tuberculosis, but at no time, even up to the present, has the distribution of beds for tuberculosis patients been such that all patients needing care could be provided for in or near the vicinity or even the state or the district of their residence.

With regard to hospital facilities for neuro-

*Dr. Emerson's resignation was accepted by the Director of the Veteran's Bureau on Aug. 12, 1921, to become effective Sept. 15, 1921.

psychiatric patients, it has been true since the beginning of this undertaking that there have been insufficient beds for the number of patients of this class known to be in need of institutional care, and many of the beds available have been so located and served as to be unacceptable according to the most modest standards. This is in part, at least, merely a reflex of the grossly inadequate facilities for either preventive, curative, or permanent domiciliary care of mental cases for ordinary civilian needs in almost every state in the Union.

With regard to the three large classes of patients, above referred to, it is well to consider in what way war service altered the number of such patients in the age and sex groups of the population who were in the military and naval forces. Without entering upon a statistical analysis for which this paper does not permit the space, it is entirely within the truth to say that aside from the deaths directly and immediately the result of combat conditions, the existence of general medical and surgical diseases and injuries of ex-service men and women is no greater than would have been the case if these same individuals had been engaged between April 6, 1917 ,and November 11, 1918, in the occupations appropriate to their age and station. In other words, military and naval service, apart from actual conflict with the enemy, was no greater hazard than industrial, commercial, and agricultural pursuits for the same age and sex groups. The same number of people would have needed general medical and surgical care if there had been no war, the chief difference being that the cost and provision for such care would have come from private or community resources instead of through Federal taxes and departments.

More Tuberculosis in Canada

In the tuberculosis field, we learn that the incidence of pulmonary tuberculosis discovered among ex-service men from the Canadian forces has been about twice what would be expected from the previous civilian experience of Canada in similar age groups. The statement cannot be made upon medical statistical evidence that any such increase of tuberculosis has occurred among the United States ex-service men and women. It would appear from civilian experience in all parts of the country that neither war nor the influenza epidemics have caused any increase in the development of active pulmonary tuberculosis among men or women, white or black, of the ages used in military and naval services.

Although it is probable that many experiences, particularly on the sea and in the areas of offense and defense in Europe, were more severe than those in civil life and possibly contributed to a development into activity of previous infection by the tubercle bacillus, it is equally true that never in the history of our country were so many men so well fed, so well clothed, and so trained and developed in hygienic living as were those in uniform during the war period, and they formed a class of selected human material.

With the neuropsychiatric group of claimants the situation is quite different, for here, through private and official channels, we have reasonably accurate evidence that most of the disorders of conduct and many of the organic diseases of the mind and central nervous system have appeared in numbers two to four times as great as would be expected from past civilian experience with people of the age group we are dealing with.

The gradual taking over of the greater portion of the load from contract to government hospitals has in the main progressed parallel with a steady improvement in the character of the care given to all our beneficiaries, so that now it may properly be claimed that the general medical and surgical patients receive care equal to the best the country affords. The care of the tuberculous has made substantial gains in the past six months, and only in the case of neuropsychiatric patients have the conditions of crowding, inadequate number, and training of attendant personnel been such that we can only feel shame for the failure of the government. Jails, poor houses, and state and county institutions are in use for our patients which fail miserably to meet the standards of modern psychiatry for curative or custodial care.

Total Will Reach Half Million

Upward of 160,000 patients had been admitted to hospitals as beneficiaries of the Bureau up to August 1, and on the experience of the Civil War veterans we may expect a total of 450,000 to 500,000 patient admissions before we reach a period in which care is domiciliary rather than hospital in character. The above figures include readmissions or multiple admissions of the same beneficiary.

While the government agencies have succeeded in keeping fairly abreast of the hospital needs except in the case of neuropsychiatric patients, in many cases hospital care has been a last resource rather than an ideal solution for the needs of the individual case.

The need for organized dispensary care will be greatly increased by the provisions of the Sweet Act. The use of private dispensaries is not thought practicable, and out-patient departments will be operated by the Veterans' Bureau and by the United States Public Health Service.

The national homes for disabled volunteer soldiers are considered to be the logical government agency for the permanent care of the sick and

dependent of the World War, and their organization and equipment are more capable of providing for this now and of expansion for the additional burden expected in the future than any other government agency.

There are so few facilities of any kind which might be called convalescent homes or hospitals that this necessary element in care and treatment of the sick may well be said to be non-existent.

It is believed that between 5 and 10 per cent of the patients discharged from general medical and surgical hospital care should be provided with from two to six weeks' convalescent care in government institutions operated as part of existing government hospital organizations or under the administrative control of a medical officer of the Veterans' Bureau, under district organization.

There is no hospital social service for hospital patients of the Veterans' Bureau provided by any government agency at present, although there is some medical social service contributed by the American Red Cross for patients of the Public Health Service hospitals who are beneficiaries of the Veterans' Bureau. There is a small nucleus (eighty) of trained medical social service workers employed by the Rehabilitation Division of this Bureau, formerly of the Federal Board for Vocational Education, operating from the district offices.

There is no adequate provision for medical social service under the Bureau, and it is felt that a Personal Service should be created to provide for proper after-care and follow-up work.

Vocational training camps or centers under medical direction have been established under the Federal Board for Vocational Education and are now being extended under the Veterans' Bureau.

The question of records for statistical analysis is entirely within the hands of the Veterans' Bureau and requires direction and personnel, and a plan for filing and indexing records as already outlined by a committee of statisticians in December, 1920, but so far not undertaken. Without a cross-index card giving for each case the vital and medical information required, it will not be possible either to check the quality of current medical services or to plan intelligently for the future. The Veterans' Bureau owes the country such a record keeping and report as will supply a true supplement to the medical history of the war now in preparation by the Surgeon General of the Army.

One of the most acute problems of hospitalization is the culling out of the patients who do not need this service. No matter what the appeal, hospitals must not be induced to give material relief in this way if medical care is not needed, for:

The object of hospitalization is not to establish, maintain, and continue the status of total temporary compensation, but to diagnose and treat the sick, and in so doing to accomplish so much by treatment that a prompt and reasonable reduction in compensation due to diminished disability may be determined.

It is the responsibility primarily of the district medical officer, or district managers, to establish such standards of examination and control of authorization for admission to hospital as will admit to hospital only those patients for whom he cannot get adequate diagnosis or treatment by any other medical or social resources.

Two auxiliary services urgently needed in every district, and especially in or near the large cities, are a neuropsychiatric clinic, and a convalescent home. The Bureau will give prompt consideration and encouragement to recommendations of district medical officers and district managers for establishment of these fundamental utilities.

There has been a surprising increase in general medical and surgical patients since June 30, 1921, which was entirely unlooked for. It seems that it must be due to the unwise admission and retention of patients.

The Sweet Act calls upon the director of the Bureau to issue disciplinary regulations and also some adequate standards of treatment.

The most important contribution yet made to the subject of national provision for hospital care of the veterans of the World War has been prepared by the consultants on hospitalization of the Secretary of the Treasury: Dr. Charles W. White, Dr. Frank Billings, Mr. J. G. Bowman, and Dr. George H. Kirby, who, in association with specialists from governmental and private agencies have studied the source of patients, their distribution by states, districts, classes of diseases, etc., and at the same time the existing government facilities for hospital care with a thoroughness which justifies entire confidence in their conclusions.

This consultant group was created by the Secretary of the Treasury to advise him as to the best way to use the appropriation of $18,600,000 (Langley Bill, March, 1920) devoted by the Congress for building additions to existing government hospital establishments of the Public Health Service and the national homes for disabled volunteer soldiers, and new hospitals for the care and treatment of beneficiaries of the Veterans' Bureau.

More Beds to Be Provided

The work of these consultants is rapidly approaching completion and all that can be said at the moment is that according to their plans 6,800 additional beds will be provided, 3,600 for tuberculosis, and 3,050 for neuropsychiatric patients. It is contemplated to spend $7,917,000 for additions to existing plants and the remainder in

new hospital establishments. Their report, when made public, if printed with the accompanying data, should be a most important document, and if followed, should leave its impression on hospital care of the ex-soldier for thirty years to come.

It is my belief that no more beds will be needed by the government for general medical and surgical patients and for tuberculosis patients when the projects about to be approved are completed. It is probable that an additional appropriation of perhaps $5,000,000 to $10,000,000 will be required to meet the government obligations for the best institutional care of mental patients, although this may not be evident for another year or so, and in the meantime the need may be met by new construction by various states for the special needs of ex-service patients.

There have been some abuses of hospitalization, Dr. Emerson continued, men seeking hospital care whose disabilities were so slight that in civilian life they would not have considered hospital treatment, but seeking it now because the compensation was better. This abuse is the outcome of a sentimental public opinion rather than a weak administration.

Dr. Emerson feels that, on the whole, the records justify considerable confidence in the consistent medical policy and medical determination of the presence and degree of disability in the majority of the claims for disability.

While a claim filed promptly after discharge, accompanied by recorded evidence of service incidence or aggravation of a disability, and supported by a medical examination made by a physician who has, accessible to him, hospital and laboratory facilities to establish a complete and correct diagnosis is easy to settle quickly and justly; as we progress farther from the dates of the armistice and demobilization, there is an ever increasing uncertainty in all elements of the claims.

To permit and to assist the claimant to present the strongest possible case to the government, he is encouraged and guided in obtaining affidavit proof, if possible, for even the most fanciful and unlikely story purporting to show service connection for the disability claimed.

Physicians' Statements Preferred

The preferred form of evidence is physicians' statements. When statements from physicians are not obtainable, consideration will be given to specific, first-hand, and disinterested statements from lay affiants. If it is the contention of a claimant that his disability arose while he was in the military service, he should produce affidavit evidence to show this from the following persons, in order of preference: (a) The medical officer or officers who treated him while he was in the military service; (b) A commissioned officer of this command; (c) Two or more of his comrades.

Detailed Personal History Most Important

The need for affidavit evidence will certainly be reduced if the medical examiner, in every instance, supplies a clear and detailed statement of the medical and industrial history of the claimant in the interval between the date of discharge from military service and the date of application for compensation.

The claimant's personal history is important, for it is quite often found that illness or social or economic conditions, since discharge, which have no reference to service, are the cause of the disability for which compensation is sought.

Some of the elements resulting in the abuse of compensation privileges are, according to Dr. Emerson, legal decisions reversing previous decisions; administration actions without medical evidence; political pressure; medical action by physicians who have succumbed to friends of the patients; press articles with ulterior motives; and appeals prompted at times by selfishness or sentiment from veterans' and other volunteer organizations.

In emphasizing the elements of error, discontent, and the causes of abuse or failure of government services it must not be understood that the majority of the claimants or beneficiaries have suffered ill treatment or have taken advantage of their government's eager offer of help.

From careful studies of large hospital populations in various districts it would appear that not more than 10 per cent of our patients and in many cases not more than 5 per cent fall in the class of troublemakers or unsuitable recipients of hospital care, and if the margin of error in just compensation ratings were found to be as much as 1 per cent it would be a surprise. A check of several thousand claims disallowed, and reviewed for this purpose by our most mature, responsible, and experienced group of medical officers showed an error of 1/10 of 1 per cent in the decisions arrived at. Errors of compensation rating are chiefly the result of pressure to give decisions too rapidly to permit of adequate study of the merits of each case.

Without the assistance and support of the various veterans' organizations and of the American Red Cross the work so far accomplished would have fallen even further below the standards and ideals which the successive directors of the Bureau have constantly set before them.

The process of coordination now actively under way with the broad powers conferred by the Sweet Act upon the Director of the U. S. Veterans' Bureau and the experience gained in the past three years should certainly result in a more rapid improvement in administration of the benefits of compensation and medical care and treatment in the next six months than has been possible in any similar period since the inception of this great constructive program of social justice made necessary by the war.

The MODERN HOSPITAL

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SUGGESTED BY THE CONVENTION

THAT the nominating committee of the American Hospital Association is an important one none will gainsay. Some serious thought should therefore be given to the geographical distribution of its personnel, its duties, and its methods of reporting the results of its deliberations to the convention. We believe that heretofore too little thought has been given to this subject, with the result that nominations have often been made without regard to the problems facing the Association and the interests of the entire hospital field. To correct this situation THE MODERN HOSPITAL suggests that in the future the committee on nominations should consist of five members—one from the East, one from the South, one from the North, one from the West, and one from Canada; that its report should be made public not later than the morning session of the third day of the convention, and that the program should be planned so as to provide for the full attendance of the delegates at the time of the election of officers. The committee, it goes without saying, should familiarize itself not only with the opinion of the membership as to the choice of officers, but also with the problems of the Association, and in the light of these factors make such recommendations as will be in the best interests of the entire hospital field. It is, of course, understood that the incoming president would not assume office until the usual time, i.e., at the end of the final session of the convention.

One further suggestion. Is it not unfortunate that the present by-laws of the Association make it impossible to have the continued services of such an able administrator as Dr. L. B. Baldwin, whose term of office as president has just come to a close, and that his knowledge of the Association's problems, gained through his year as president, should not be at the disposal of the Association for at least one year following the expiration of his term of office? This desirable end could readily be attained by a revision of the by-laws, making the retiring president an ex-officio member of the board of trustees for one year.

TRUSTEES VS. ADMINISTRATORS

TRUSTEES versus administrators! Too often this is the situation in hospitals. It arises from a failure or, as often occurs, a flat refusal on both sides, to recognize the well defined jurisdiction of each, and to remain strictly within that jurisdiction.

A problem in every hospital is the harmonizing of the two elements:—the trustee on one hand and the administrator on the other, for the purpose of producing interest and cooperation.

It is a common failing to be interested in the other fellow's job. The layman can always give advice to the professional. The expert is picked to pieces by his clerks. Preconceived notions among the ignorant and uninformed are responsible for the failure of many worthy enterprises, hospitals among them.

Hospitals are considered public enterprises. Even though they may be privately endowed and independent financially, the community expresses a certain interest in them because they are humanitarian. But the average run of hospitals are dependent upon the community for support; consequently the community has both a financial and humanitarian interest in their operation.

This interest in the local hospital is expressed in criticism of its management and methods. To maintain the source of support the hospital must keep in harmony with the contributing public.

Here is the root of the trouble between the trustees and the administrators. Trustees will not confess responsibility for lagging financial response. They blame the superintendent. The administrator will contend that, being a professional man and knowing his business, he has conducted the professional work properly. The trustees want to dip into the internal management, and the administrator thinks he could raise the money and spend it more efficiently. In a very

short time the two elements are entirely in each others territory and a state of chaos exists.

The public, first of all, must learn to keep its hands off. A hospital is a being of small and weak beginning which grows by slow accretions. Its policy and methods are not to be determined by shifting winds nor can its success or failure be judged by a few years' trial.

Trustees must learn that "business" is their object. They are concerned with the preservation of the property, the building up of endowment, the upkeep and enlargement of the physical plant. Trustees are not called upon to know anything about medicine or medical practice in any of its ramifications. Nursing is entirely beyond their sphere.

If the trustees of a hospital will study the organization of a great and successful mercantile or manufacturing enterprise, they will quickly begin to recognize their legitimate function.

In such an enterprise the interest of the board of directors is developed to its highest degree. They determine upon certain fundamental policies, provide the funds with which to operate, and place at the administrative stations men of technical training and skill who are expected to get the results. There is never lack of harmony between the board and the administrative officers of a successful business undertaking, because each understands where the boundary lines are, and each keeps on his own side of them.

So the trustees of a hospital are a board of directors, with well defined duties to perform. The administrator selected by them should be a man trained and skilled in his profession. He must get the results that any novice knows a hospital should produce.

If, having had full liberty within his field, he does not produce these results, if he is by temperament unfit, or lacks training, skill, or capacity, the board should be able very quickly to discern the fact and make a change. The getting of hospital results, be it remembered, is always the responsibility and the duty of the administrator. This is not the province of the board of trustees and it cannot rightfully assume credit for such results, except in so far as it exercised good judgment in picking an administrator.

The cause of friction between these two spheres is entirely due to failure or refusal of one or both to know his field and remain within it.

A successful hospital should not have to worry about interesting its trustees. No man or woman should accept a trusteeship who does not intend to perform the duties faithfully and promptly and with an eye single to the hospital's success. When he has a personal ax to grind or goods to sell or favorites to reward he is worthless, and will be unconcerned in the true sense of the word, no matter what may be done to arouse his interest. No trustee should sell directly or indirectly, or enjoy the advantages of patronage. Endless friction results when this is the case.

The main point to be emphasized in establishing harmonious relations and stimulating the interest in a hospital organization is that each side should understand its duties, know its field and stick closely to its own affairs. The whole lesson of successful management and operation may be read in the methods of a successfully organized business enterprise.

HOSPITALS ADD TO THE BURDEN OF THE "AVERAGE" MAN

A RECENT editorial in the *New York Times* remarks that although the Johns Hopkins University has inaugurated a movement to regulate the fees which a surgeon may charge for operations, this gives little relief to the large number of people of the middle class who cannot afford to go to the best surgeons for treatment. If they were a little poorer or a good deal wealthier their case would be taken care of. This fact is realized by medical men, and there is talk of the necessity for a sort of clearing house where a patient may go to have the nature of his ailment determined, receive treatment, and finally pay one bill for the services rendered. As it is he goes through a maze of treatment, and pays fees to the doctor, x-ray men, pathologist, surgeon, anesthetist, trained nurse, and others, exclusive of hospital board, until as the editorial puts it "he emerges into the class of the bankrupt."

The story of the "average" man passing through the hospital is told with feeling by one who has just done so, and who although he did not feel that charges were excessive yet found that his illness cost him $521, $371 above the surgeon's fee. He was in the hospital eighteen days. If he had realized how much the operation would cost he would have felt as do so many others no doubt, that he must put it off until a later time.

Another thing which has been brought up more than once by the "average" patient is the fact that when he arrives at the hospital door invariably only the most expensive rooms are vacant. Why is this? It is partially and simply explained by the fact that the $5.00 rooms are engaged by the well to do, or for that matter, by anyone, before the $9.00 ones. Then when the average patient, who has waited until his case is urgent, arrives at the hospital with no room previously engaged he is relentlessly put in the $9.00 room. Could there not be more inexpensive rooms? And are there not other ways in

which hospital methods can be made to add less of a burden to surgical costs?

A DEMONSTRATION OF ADVANCE

IT WAS refreshing to read what M. Goossens-Bara, director of hospitals and charities of Brussels, had to say (THE MODERN HOSPITAL, September, p. 194) about the superiority of American hospitals and medical education.

He is very generous in his expressions, yet it is evident that what our hospitals and medical schools have been doing in coordinating themselves, is a distinct improvement over the situation in Belgium and other parts of Europe. What has been done here in "hooking up" the hospital and the medical school to mutual advantage impressed M. Goossens-Bara. He came to study them and to learn how to apply our methods in his country. We have believed we were on the right track. The endorsement of our ideas and plans by one who has grown up in a tradition of centuries is splendid evidence that we have made an outstanding advance in medical education.

MAKING HOSPITALS MORE HOSPITABLE

WHY should all wards be furnished and equipped in the same manner? In many hospitals, as Mr. Arthur Peabody in his article on "The Human Side of the Modern Hospital," on page 268, points out, the contagious, non-contagious, surgical, and obstetric wards are all alike in their uniform greyness, metalness, and blankness. It reminds one of the bed which the giant in the fairy tale had in his guest room. Instead of the bed being changed to fit the guest, the guest was altered to fit the bed. If he happened to be a little too short he was stretched out, if too long he was simply lopped off. Mr. Peabody suggests that if the clientele of our hospitals were only sufficient, we could imagine the patients progressing in a steady stream to the sorting room, thence to the divesting room, the bath, anesthetizing room, the cutting off room, the assembling room, the finishing room, the seasoning room, and finally to the shipping platform. Could anything be more delightful—or more efficient? But suppose through some slight administrative error, such as must often occur in such large plants, a typhoid fever case should accidentally land in the cutting off room, and be separated from an arm or a leg, before he had a chance to remonstrate? O terrible thought! And yet the mental treatment of patients is as standardized and inhuman.

Have you ever had to lie for hours and look at an impressionless white ceiling and wall? We speak with feeling for we have. Or rather, ours was the color of salmon salad with mayonnaise dressing on it. It was terrible. It drove every happy iced tea or peach ice cream thought from our head, and left—salmon salad. Why not give the unhappy patient the diversion of counting rosebuds around the border, or wondering why the paper hanger never, through pure accident, joined the design in the right place?

Extra expense and labor you say? If we had space we could easily refute these arguments, for we have the article above mentioned well in mind; as we have not—we refer you to said article for the answer to your startled exclamations.

THE QUESTION OF PRISON HOSPITALS

THE American Prison Congress meets in Jacksonville, Fla., October 28 to November 3. Glancing over the preliminary sketch of the program, we are disappointed in noting the small space given to the medical aspects of prison administration. A small group of scientific men are to hold a meeting by themselves, but their relationship to the big organization is slight, though it ought to be first.

Prison hospital construction and facilities are not mentioned. Yet we know of nothing, in the light of present day knowledge about men and women who fail to fit into society, that is so important as their mental and physical health. An understanding of their deficiencies, acquired by study of them in their early lives and the application of remedial agencies might have saved many from criminal careers. But certainly restoration to normal life is not possible in prison without a definite knowledge of the man, his physical, mental, and moral constitution. The knowledge cannot be obtained by untrained men. Education and professional training of the highest type are required to study prison population and apply remedies that will insure even a chance to the convict. Nor can experienced and trained men perform their duties without such facilities as a hospital service affords, including every function which we believe to belong to a modern hospital.

The care of the daily health routine of prisoners is not enough. The prison is bound to become more and more a diagnostic laboratory for the study and readjustment of broken and criminal humanity; but prison officials do not seem to be awake to the trend of the times or the real needs of their institution.

The American Prison Congress is one of the great welfare organizations of the nation. Its program does not measure up to the situation.

PRACTICAL ACCOMPLISHMENTS MARK WEST BADEN CONFERENCE

EVEN the casual observer could not escape the impression of cordiality and good-fellowship that prevailed at the West Baden Conference. As one sauntered about the lobby, the atrium, and the attractive grounds of the hotel, even during the period of the day when meetings of the Association were in progress, one saw here and there small groups of superintendents and trustees in informal conference over some problem with which one or all of them were grappling, or studying the rough sketch of some contemplated building project. One superintendent said that he had become better acquainted with his confrères in the hospital field at this convention than at any previous meeting of the Association, and he had attended many. This, of course, was due in no small measure to the absence of outside attractions. Nestled among the hills of southern Indiana, away from any large center of population, the meeting-place offered no opportunity for the inspection of hospitals and allied institutions. While there were ample opportunities for varied recreation, there were few outside attractions such as one finds in the large cities, and the members were content to spend what little spare time they had at the hotel.

DR. GEORGE O'HANLON
President
Medical Superintendent, Bellevue Hospital, New York City

Reception Committee Most Helpful

The reception committee of the Indiana Hospital Association had much to do with the spirit of cordiality and acquaintance which prevailed throughout the meeting. In many instances members of this committee made it their business to see that delegates who desired to meet each other received the necessary introductions. But despite this general impression of good-fellowship there is still room for improvement along this line. A goodly number of the newer members of the Association failed to widen their acquaintance among the hospital fraternity to any extent, due not wholly to their own timidity, but to the lack of suitable opportunities for getting acquainted. To correct this situation one of the members offered the suggestion that during each meeting an opportunity should be given to the delegates to rise and introduce themselves to their neighbors. In this way in the course of the various sessions many new acquaintances would undoubtedly be made. But whether this is a practical suggestion or not, some plan should be worked out under which a larger number of delegates would become acquainted with each other. Perhaps two or three members of the reception committee, known for the time being as social secretaries, might solve this problem by devoting their time to the specific task of introducing delegates. That this is an important aspect of the annual conference is evidenced by the testimony of many that in the opportunities for social contacts and informal discussions lies the chief value of the convention.

Sessions Business-Like

On the whole, the various sessions of the Convention were conducted in an expeditious and business-like manner. The sesions usually started promptly, but this meant that many delegates came into the metings late, and because of the noise and confusion they created, distracted the attention of those who made it a point to be on time. It would be well to make some effort at succeeding conventions to discourage this practice. It is unfair alike to the first speaker of the session and to his audience. To discourage this practice the Association might deem it advisable to go so far as to close the doors after the first speaker has begun, and not open them again until he has concluded his address.

Plan for Round Tables Suggested

Several of the round tables were conducted in an admirable manner. But failure to hold speak-

ers rigidly to the subjects under discussion, and to organize the material of the round tables in advance, kept some of them from being as helpful and stimulating as they might otherwise have been. We believe the following plan of procedure would yield excellent results. As far as possible let the person conducting the round table organize the subjects to be discussed in advance of the meeting, eliminating pointless questions and grouping desirable ones in some logical form. After stating the question, throw it open for unassigned discussion, which the chairman should insist upon being brief and to the point. When no one has any further contribution to make to the subject, let the chairman call upon some previously chosen member to sum it up.

Too Many Sessions

The feeling was quite general that the days were overloaded with meetings. Once the Convention got under way there was no respite. There was little opportunity for recreation unless one deliberately ignored some of the meetings. Many in fact did this after the first day, when, after three successive meetings, they found that their brain cells ceased to function efficiently. The laws of fatigue place certain definite limits upon the mind's ability to grasp and hold ideas, and to the extent to which the Convention went beyond these limits, it failed of its purpose. Why should not the American Hospital Association follow the commendable example of several national bodies whose annual meetings are models of efficient organizations? These organizations plan their convention in such a way as to leave part of each day, either the afternoon or the evening, free from formal meetings, in order that their members may engage in their chosen form of recreation; visit the commercial exhibit, if there be one; confer with their associates; hold committee meetings; visit institutions and other points of interest; or go to some place of amusement. These intermissions enable members to get the most out of the formal meetings of any convention. Quite as varied a range of subjects could be covered, if thought necessary, by limiting the papers to twenty minutes, with ten or at most fifteen minutes for discussion. Long papers might very properly be given only in abstract, the complete papers appearing later, either in the hospital magazines or in the printed proceedings of the convention.

More Time Needed for Exposition

A plan of organization such as has just been suggested would leave the delegates more time to devote to the exposition of equipment and supplies. A deliberate effort was made by the Association this year to give the exposition a distinct educational, as well as, commercial aspect. In some measure this was accomplished, but if the exposition is to fulfill its proper function as indicated, would it not be advisable for the president to be authorized by the trustees to appoint committees to inspect the exposition on the first day of the convention, and report to the Associa-

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tion in general session on the morning of the following day. Let one committee survey the exhibits on construction and allied materials, another the exhibits of food and food equipment, another the exhibits of surgical equipment and supplies, etc., and in this way have the Association take official cognizance of the various exhibits comprising the exposition. One afternoon or evening might, moreover, be officially set aside for the inspection of the exhibits by the delegates in addition to there being ample time allowed between sessions throughout the convention.

Report of Record Forms Vital Contribution

The Conference was characterized by certain very definite, practical accomplishments. The admirable report of the committee on hospital forms and record-keeping is unquestionably one of the most noteworthy pieces of work that the Association has accomplished. For many years the hospitals have felt the need for a well-thought-out system of records, that would make comparison of statistical data possible. This report offers an open door to the accomplishment of this purpose, and it is earnestly hoped that hospitals generally will see the wisdom of adopting these forms and methods of record-keeping. Although the report of the committee on hospital flooring was not completed in time to be presented to the Convention, it gives promise of furnishing the basis for certain well-defined standards of hospital construction, which will be of real value to future builders of hospitals. The work of the committee on state subsidies and of the committee on the relation of hospitals to states and cities, while tentative in character, will undoubtedly lead to results of practical importance to the hospital field.

International Aspect Should Be Emphasized

The membership of the American Hospital Association is made up not only of citizens and institutions of the United States, but also of Canada, and to this extent the Association is international in character. Yet in the scheme of decoration the Union Jack was missing; this was of course merely an oversight, and will in all probability not occur again. The hospitals of Canada are growing both in number and in bed capacity, and most of them have met the minimum standards of the American College of Surgeons. Every effort should therefore be made to emphasize the international aspect of the scope and work of the Association. Our sister republics to the south are making splendid progress in hospitalization and we think it would be wise for the trustees to extend an invitation to the Central and South American countries, also Mexico to send delegates to the next annual conference.

Trustees of Hospital Meet

One could not but be impressed by the possibilities for growth that lay in the special meeting that was held for the trustees of hospitals. To be sure the meeting was small, there were but twenty-five persons present, but it was

Official Photograph by Underwood and Underwood, New York

Association, West Baden, Indiana, September 12 to 16, 1921. (Continued on the following two pages)

big in possibilities for developments of the right kind. The Association is now clearly an association of institutions, as distinguished from an association of superintendents, and as such must command the active interest and support of hospital trustees. This inconspicuous meeting gave promise of starting a line of action whose purpose is to win that interest and support. In fact a motion was made and carried, requesting the board of trustees of the Association to establish a trustees' section, as one of the first steps toward carrying out this purpose. It is to be hoped that this request will be acted on favorably at an early meeting of the board of trustees.

WHAT HAPPENED AT THE CONVENTION

THE GENERAL SESSIONS

IN THE absence of Governor W. T. McCray of Indiana, Dr. George F. Keiper, president of the recently organized Indiana Hospital Association, which acted as the host of the Conference, welcomed the members in a brief and happily phrased address. He took occasion to point out that in organizing the hospitals of Indiana as a geographical section of the American Hospital Association, they have provided for the membership of physicians, realizing that the 60,000 physicians in this country connected with hospitals in an official capacity have a vital interest in their management and development. This step he thought was new in so far as state hospital associations are concerned. He also urged states that had not thus far organized associations to do so during the coming year.

Dr. Baldwin Outlines Hospital Field Activities

In his address as president, Dr. L. B. Baldwin, superintendent of the University of Minnesota Hospital, said that the American Hospital Association is today entering upon the period of hospital service in the interest of the community. He suggested some of the activities by which this service may be effectively and efficiently realized. Some of these were: the suitable classification of hospitals, and the education of the public as to the particular function of each; the making of a social survey of each community so that each type of hospital may fulfill its social need; affiliation between public and even selected private hospitals with the public health service of the community for the hospitalization of venereal and other contagious diseases; freeing hospitals from political influence; the development of a higher type of hospital executive; the development of a more efficient business system;—these and other vital points were taken up by the president.

Trustees Report Important Activities

The report of the board of trustees (printed in full on p. 325) dealt with the business transacted at the four meetings during the past year. At these meetings the financial and other reports of the Association were presented and considered, and special action was taken on certain questions, among them the following:

The Wisconsin Hospital Association was accepted as a geographical section; a service bureau on hospital social work was established; the report of the director of the Service Bureau on Dispensaries and Community Relations was approved. Resolutions were adopted favoring the treatment of pulmonary tuberculosis and venereal disease in general hospitals, and the performance of autopsies in hospitals. The request of the Protestant Hospital Association to become a section of the Association was refused because no such provision is made in the constitution.

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The president was authorized to appoint a committee to study the formal relation of states and cities to the hospitals and dispensaries located therein.

The report of the membership committee (printed in full on page 329) was read by its chairman, Dr. C. W. Munger, superintendent, Columbia Hospital, Milwaukee, Wis. This report shows that the Association at present has 368 institutional members, 1,982 active personal members, 204 associate personal members, ten honorary, and thirty-one life members. The committee urged the members of the Association to make an effort to secure a substantial number of new members during the coming year.

Mr. Michael M. Davis, Jr., submitted the report of the Service Bureau on Dispensaries and Community Relations, as its director. The purpose of the bureau, which was established about a year and a half ago, is to give service to the members of the Association and others by answering inquiries regarding the organization or management of dispensaries, and regarding the community needs and relationships of hospitals. During the past year some fifty-nine different organizations have applied to the bureau for information or advice; sometimes the reply from the bureau involved little more than a routine answer, but in many cases considerable investigation, and not infrequently a fairly detailed report to the inquirer, was necessary. The correspondence of the bureau included over seven hundred letters. The bureau conducts field studies or surveys of institutions or communities, at their request, and during the past year seven such studies have been made. For instance, the plan of organization of a new out-patient department at St. Luke's Hospital, New Bedford, Mass.; the community needs of Glen Falls, N. Y., with reference to the development of the Glen Falls Hospital; the question of need for the enlargement of the City Hospital of Detroit; dental clinics in the large cities of the country. The last study required intensive investigation of seven cities, and some study of over thirty other communities.

Mr. Davis has been assisted in the work of the bureau by a number of persons, among them Dr. Gertrude E. Sturges, formerly associate director of the Cleveland Hospital Survey; Miss Anna C. Phillips, formerly of the staff of the American College of Surgeons.

In his report Mr. Davis included impressions gathered, during one and a half years of the bureau's existence, of over sixty institutions or communities scattered all over the country. This portion of his report is to be published as a bulletin of the American Hospital Association. Mr. Davis said that one of the common difficulties of the hospitals was deflation of the pocketbook. He indicated that in many instances this condition was due to the fact that hospitals were charging rates that were too low to meet their actual costs. He felt that there was no excuse for patients paying less than the cost to the hospital.

Mr. Davis felt that few hospitals have studied out the needs of their communities or cooperated with each other to a common end, and that altogether too often hospitals are subservient to medical cliques. He urged hospitals, through the adoption of new methods and the readjustment of physicians' and surgeons' fees, to provide more adequate facilities for the care and treatment of people of moderate means. Too many hospitals, he held, were slow to perceive that they can get financial support from the public if they give the public what it actually needs. In not a few hospitals the bureau found improper organization of the medical staff, which was either under the control of one doctor or of a small handful of doctors. He emphasized the necessity for adequate organization of the board of trustees and a proper bestowal of authority upon the superintendent. In closing, Mr. Davis contended that the standards of the American College of Surgeons needed to be supplemented by further fundamental standards of hospital organization and administration, promulgated effectively and authoritatively by the American Hospital Association.

Miss Ida M. Cannon, director of the social service department, Massachusetts General Hospital, submitted a report as director of the Association's Service Bureau on

Association West Baden, Indiana, September 12 to 16, 1921.

ASA S. BACON
President-Elect
Superintendent, Presbyterian Hospital, Chicago, Ill.

Hospital Social Work. Miss Cannon indicated that the scope and purpose of the bureau was, first, to answer inquiries regarding hospital social work; second, to promote and disseminate the principles declared in the Association's report on hospital social service work published during the past year; and third, to consider the problems of hospital social service work from the point of view of administration.

During its brief existence the bureau has issued bulletins, answered some forty inquiries, studied various problems of social service work, and formulated its tentative program. One of its problems has been the application of the principles of hospital social service, not only to the smaller, but also to special hospitals, such as hospitals for the insane and for the tuberculous.

The bureau has undertaken the preparation of a directory of social service departments, of which there are now about 370 in the country. This will be placed for reference in the hands of the Hospital Library and Service Bureau.

In outlining the bureau's program for the future, Miss Cannon pointed out that this would have to be built on the needs that exist, and to this end the hospitals must let it know what these needs are. In the meantime the bureau will continue to answer inquiries, clarify the conception of what social service work is and what its functions are. Time will be devoted to a further study of the training of hospital social workers, and to the relationship of the American Hospital Association to the American Association of Hospital Social Workers. In closing, Miss Cannon emphasized the importance of applying the principles of hospital social work to the smaller hospitals throughout the country.

Dr. Warner Points Way to Wider Activities

In his report as executive secretary (printed in full on page 326), Dr. Warner told of the growth in the membership of the Association, both personal and institutional, and the increased strength of the Association's organization for service.

The real question now is, will the Association use the opportunities which are before it and step into the field as a leader and an organizer, or will it let things drift? The hospital should be organized, existing standards should be put into more general use, and many other things are crying to be done.

"Salaries Hospital Superintendents Are Now Receiving" was the subject of a paper by Mr. Joseph J. Weber, managing editor of THE MODERN HOSPITAL, (printed in full on page 347. The data, which were carefully compiled, made possible certain statements of general application. First, equal pay for equal service does not prevail; men, on the whole, receiving higher salaries than women. Women predominate as superintendents of the smaller institutions, as might be expected. Another interesting thing revealed by the study was the fact that in a large number of the groups a relatively small number of superintendents receive salaries well above the average, while the salaries of the majority were below the average. This was true of both men and women. The maximum salary among women superintendents was $5,400, for the executive of a 150-bed hospital, and the minimum salary was $1,200, the executive of a ninety bed hospital. In the case of men the maximum was $18,000, the executive of a 485-bed hospital; the lowest $1,740, for the executive of a sixty bed hospital. It was found, on the whole, that hospitals supported by private funds paid higher salaries than those supported by the public treasury.

At the General Session on Tuesday at 2 p. m., with

DR. MALCOLM MACEACHERN
First Vice-President
Superintendent, Vancouver General Hospital, Vancouver, B. C.

President Baldwin presiding, Dr. C. S. Woods, superintendent, Methodist Episcopal Hospital, Indianapolis, Ind., gave a very interesting talk on professional efficiency in the hospital. He said that he felt that everyone familiar with hospitals must feel that this subject has not had in the past the consideration which it deserves. The hospital must show itself worthy of a patient's confidence by actually enhancing his possibility of recovery. This is probably the most important factor in the public health program. The question of professional efficiency in the institution Dr. Woods took up from two points of view. First, that of the professional organization and work in the hospital. Under this he emphasized the equipment of laboratories, the better administration of anesthesia, the more accurate sterilization of all goods which may come in contact with the field of operation. The technic in the operating room must not be a matter of routine only, but should be thoroughly understood by those taking part. Efficient, rather than elaborate technic, said Dr. Woods, must be adopted. The organization and operation of other laboratories, aside from the surgical is important; also the use of these facilities by the physicians and surgeons. The proper nursing and intern personnel should be provided. Professional records, to which there seems to be a professional indifference, are also very valuable.

Considering the point of view of attending physicians and surgeons, Dr. Woods made three points. First, there is a mutual obligation between the attending physicians and surgeons and the officials of the hospital. Second, the professional man who does work in the institution becomes for the time being a part of the organization. Third, what the professional man is reflects on the hospital and becomes part of its tradition and history. The best way, then, for him to raise the standard of the institution, is to do the most efficient professional work possible, and cooperate willingly in the furtherance of the highest ideals. Dr. Woods considered that there could be no argument on the question of the prerogative and duty of the institution to exclude certain professional men from doing work within its walls.

DR. HAROLD W. HERSEY
Second Vice-President
Superintendent, New Haven General Hospital, New Haven, Conn.

HARRIET S. HARTRY
Third Vice-President
Superintendent, St. Barnabas Hospital, Minneapolis, Minn.

Paper Brings Forth Active Discussion

In a discussion of Dr. Woods' paper, it was stated by one superintendent that when some members of the staff had been eliminated because they did not measure up to the hospital standard, it was found to be a good thing, because better physicians came into the hospital, bringing their patients, and the beds were more full than before. He also said that laboratories should be established, and that the superintendent should demand that they be used, and that patients be diagnosed thoroughly before going to the operating room.

Another superintendent said he felt that often patients went to the operating room without any preparation, or with few examinations having been made, because the physician who referred the case was an important person, and no one dared to question his diagnosis. Proper, painstaking histories will prevent operations for appendicitis on a typhoid fever case. He made the somewhat startling announcement that he was sure he had seen patients operated on, not for appendicitis, but for $150. He also felt sure that operations had been performed to bolster up the case record of the operator. These practices must be stopped. It was suggested in reply to this that in some hospitals every organ removed in operation must be sent to the pathologist, and if they are normal the operator must answer.

Mr. W. P. Heath of Chicago, Ill., then spoke on "Food Preservation." He said that he was there to tell the story of the new sanitation for dairy products. Air, he said,

is the cause of butter becoming rancid. It was found several years ago that the air bubbles entering into butter during its manufacture were responsible for millions of dollars loss annually. Air was found to be responsible for the "off flavor" of butter. Exposure to air also destroys vitamins. But more important than these two reasons for the elimination of air are the sanitary reasons. Atmospheric dust, according to some physicians, should be ranked with noxious insects and contaminated water in respect to its dangers. Air in crowded buildings contains from 20,000 to 40,000 dust particles to the cubic inch, while clean air, which mortals never breathe, contains never less than 3,000. Statutes have been passed in New York forbidding exposure to the air of food which is to be sold.

Early scientists began to work for the means of excluding air, and Mr. Heath recognized that the air must be replaced by a gas fulfilling certain requirements. After experimentation, carbon dioxid was chosen, because: It could be free from dust; it does not destroy vitamins; it is heavier than air, therefore good for replacement; it suffocates bacteria. Experiments had proven that food could be kept for years in carbon dioxid. Experiments were made with this atmosphere and it was found that the carbonated butter had a better flavor, and far superior keeping qualities. This gas intensifies the natural flavor, which is an added advantage, as only the best materials can then be used.

Ice cream is one-half air. One of the eleven steps in its manufacture is the freezing in of this air, which is now being replaced by carbon dioxid in many factories of the United States and Canada. Two hundred manufacturers of dairy products within this territory use this carbonation, and there has never been a case of illness from their products. Hospitals, concluded Mr. Heath, are path-breakers in sanitation. This is one of the things which they must take up in the future.

At the General Session Tuesday evening, Dr. Haven Emerson, who was, until recently, medical advisor and assistant director of the Bureau of War Risk Insurance, Washington, D. C., delivered an address on the medical and hospital care of the beneficiaries of the United States Veterans' Bureau. An abstract of this address appears on page 282 of this issue.

Trustees Turning More and More to Association

One of the small, though significant, meetings of the Convention was that called for hospital trustees, Thursday evening. Dr. A. R. Warner, executive secretary of the association, acted as chairman. He pointed out that in the selection of boards of trustees the tendency was away from so-called society people, charity workers, and good fellows, and toward the selection of well qualified men who have a real interest in the work of the hospital. He said that the American Hospital Association had left the stage of being an association of hospital superintendents ten years ago, and was now an association controlled by the hospitals themselves.

Hospital trustees in increasing numbers, he pointed out, want to get information direct from the Association, and are going direct to the Association for it instead of waiting for it to come to them through the superintendents.

Dr. Olsen, of Englewood Hospital, Chicago, pointed out that it was important to find out what trustees are interested in and then have more papers on these subjects, followed by general discussion regarding any matters that they might wish to bring up.

Dr. Warner pointed out that the American Hospital Association now had in its files the names and personal addresses of about 3,000 hospital trustees, connected with hospitals in one-third of the states. Following a general discussion of how the American Hospital Association might reach trustees, it was agreed that the following program of action should be carried out: (1) Send trustees a letter addressed to their present address, stating the service which trustees may secure from the Chicago office of the Association. (2) Follow this letter up with bulletins in brief, concise form, incorporating principles of hospital organization and management. (3) Leave the question of membership until the trustees have had some service from the Association. (4) Request the trustees of the American Hospital Association to organize a section on trustees.

The Dietitian an Asset to the Hospital

At the General Session on Dietetics, Friday morning at 10 a. m., Miss Rena S. Eckman, in her paper on "The Dietitian as an Asset to the Hospital," outlined the evolution of the dietitian in the hospital in the words of a superintendent of nurses, who once said: "At first we wondered what to do with her. It seemed as if she might be an asset. But anon we also wondered if she were not a liability. . . . But we found that after a certain amount of orientation had taken place, many conditions were so much improved that we should not think of going back to the time when there was no dietitian."

There are many fields of usefulness open to the dietitian. In buying equipment and supplies, handling of labor, and technical supervision of cooked food products are found phases of her vocation. Business institutions, such as banks and factories, are finding it economical and beneficial to employ a dietitian, and this means that they consider the work of the dietitian a business asset, rather than a liability.

For her work the dietitian must have adequate training. Certain principles of standardization should be applied to schools for dietitians, and then an internship in a hospital should be provided before the student is given a place on the hospital staff.

Dietitian Should Supervise Hospital Equipment

But returning to the duties of the dietitian, first, and not least important, is the supervision of the equipment of the hospital. Think of the saving that can be effected with a little care, in linen, dishes, silver, and power machinery. All of this equipment represents a vast amount of money. Then there is the inspection of food at its entrance to the hospital, and its care until it is served to the patient. Food is a large item of expense, and much of it is wasted because of the poor quality that has been purchased. Care in the feeding of patients has been found to be a part of the dietitian's work, outside of hospitals as well as within them. Making food attractive, and preparing properly balanced diets is extremely important, with adult patients and with children. Dr. Dennett, in an address before the American Dietetic Association in 1921, said, "The modern trend in the care of children involves a maximum of dietetics with a minimum of medicine."

In the matter of the replacement of equipment, remodeling of kitchens or planning new ones, the dietitian may also be of practical help to the institution. The economical balancing of menus is another way in which the dietitian may save money, for combining an expensive meat with an inexpensive dessert, or vice versa, makes for more intelligent distribution of the budget.

Miss Eckman advocated the further development of a center of production, i. e., a central kitchen where more

things such as soup, ice cream, vegetables, and certain kinds of fruits will be prepared.

In closing, Miss Eckman stated her faith in the adaptability of the dietitian. Adaptability or death has been her rôle in the past, and she feels sure that, as new fields open in the future, she will enter into them and continue to be an asset to hospitals, as well as to cafeterias and food industries.

Personnel Watched for Source of Infection

Mr. Pliny O. Clark, Denver, Colo., opened the discussion by describing the sunny central kitchen which he has in his hospital, with separate serving kitchens on each floor. Dr. Munger told of the complaints he had received on the food in his hospital being cold and unpalatable and the serious time he had with infection, two epidemics occurring among kitchen employees. He now has a medical examination of a thorough type of all employees. They are also vaccinated, and their hands are examined for infection. Miss Young, Nicholls Hospital, Battle Creek, Mich., said that she has the trays taken up on the floors first and the food brought in conveyors. It takes eight minutes for the serving of each floor. Dr. Howland, superintendent, Peter Bent Brigham Hospital, Boston, said that in the private wards all diets were served from the main kitchen in the basement by means of electrically heated carts. He made the point that nurses cannot make the trays look as attractive as can a trained dietitian. Since milk is such a dangerous source of infection, he feels that it should be handled by one person, this person, in his hospital, being examined every day as to throat and hands by the assistant superintendent. Mr. Chapman, Mount Sinai Hospital, Cleveland, Ohio, said he has a re-examination of every person in the hospital every sixty days, and of the dietary department every thirty days. The superintendent of a 175-bed hospital said that she used a food cart coming from the central kitchen, and the trays were fixed attractively with flowers and finger bowls.

Still Need Better Training for Dietitians

Miss Graves said that this discussion only pointed to the fact that there must be better training for dietitians and nurses along these lines. Another superintendent having 126 beds in three different buildings used the system of dumb waiters and underground passages. Dr. Howland was asked how his milk was handled. He said it was pasteurized, then emptied into porcelain-lined dairy vats. It is tested once a week. Mr. Chapman suggested the advisability of testing it as it enters the hospital, and again as it reaches the patient. In Dr. Howland's hospital the head nurse is in charge of the diet, and makes rounds to see that everything is all right.

Miss Graves then asked the question as to what should be the proper title and status of the dietitian, asking Dr. MacEachern to answer it. He gave the title as "director of dietetics," and the status that of being completely in charge of food, including kind, quality, preparation, and service.

Cooperative Purchasing Urged

At the General Session on Friday morning at 11 a. m., at which President Baldwin presided, Mr. Guy J. Clark, purchasing agent of the Cleveland Hospital Council, Cleveland, read a paper on cooperative purchasing by hospitals. During the first six months of the purchasing department little purchasing was done by the hospitals, but gradually by a method of education they came to see the advantages both of price and quality which were theirs for the asking. Although the department does not aim to save money, but merely to get the full value for money spent, yet it does make a definite saving through placing large orders, amounting in the case of meats to 10 per cent. There is also the saving which is hard to prove but is nevertheless there, realized by buying on requisition.

Better service is naturally the result when the vendor is risking the loss of the trade of twenty institutions rather than one. Meats and canned vegetables and fruits are bought on specifications which have been sent to the members of the Association by Dr. Warner.

The plan has worked and is working successfully in Cleveland, and Mr. Clark's exposition of the results was an argument for its being tried in many other places.

In the discussion of Mr. Clark's paper, Dr. Warner asked how standardized dressings were working out, and Mr. Chapman, who took the chair on account of the indisposition of Mr. Clark, said that the committee had cut down the number of sizes from 175 to eighteen. The reclaiming of gauze being taken out of the hospitals had been a great saving of money and trouble. He also said that standard specifications were furnished to the hospitals, and if the supplies did not come up to these specifications they were rejected by the hospital administrator. The Council is merely an agent, the hospital having the responsibility. Someone asked how much time elapsed between the receipt of the order and delivery. Mr. Chapman said that the system was necessarily predicated on the anticipation of wants, and that several days sometimes elapsed. For example, Tuesday is grocery day, and if an order is sent in on Wednesday, the supplies would probably not be received until the following Wednesday.

No Trouble with Replacements

The question of replacements is not difficult. It is a matter between the hospital and the vendor, although it goes through the Council because it has the organization to handle it. Dr. Conley, of New York City, said that in New York it was difficult to get replacements because the vendors were so slow in making them, but it was stated that there is no trouble of this kind in Cleveland. Mr. Clark, who again took the chair at this point, asked for a show of hands as to how many were following the specifications of the American Hospital Association which have been received by all members. One or two put up their hands. One private hospital had its own specifications and some city hospitals had those imposed by the municipality. Mr. Clark could not be emphatic enough in emphasizing the importance to a hospital of this saving of money and bettering of supplies. The Council has sufficient purchasing power to demand and get good service. He believes the average hospital has the loosest kind of purchasing system of any business in the country. Salesmen constantly prey on hospitals and the reason is that department heads who have no aptitude for buying "place orders." You cannot place orders and buy at the same time. Mr. Pliny O. Clark said that it was his opinion that the average superintendent was no good as a buyer, and that this purchasing council solves one of the hardest problems in hospitals today.

Mr. Guy J. Clark continued that canned goods give the best chance for fraud of anything sold to hospitals. Most hospitals buy labels, but labels mean nothing. One Philadelphia hospital superintendent said that the specifications of the New York purchasing bureau were too low. The superintendent stated that he had cut down the cost of dressings 66⅔ per cent, and had saved $80,000 since he began the system of having four instead of eighteen sizes. They are large at first and trimmed to a smaller size after

each washing. Mr. Clark said that the New York specifications were high enough for any hospital except in certain instances which might be cited, where the goods were probably a special buy. The trouble is hospitals do not use it and do not get the service that they could. In Cleveland the Council is financed by the community fund and charges no fee from hospitals. The spirit of cooperation in Cleveland among hospitals, he said, could not be surpassed anywhere. When asked if they kept a cost accounting system to see how much money was saved, Mr. Clark said the object was not to save money but to get a dollar's worth of goods for a dollar. Superintendents are too busy to watch market conditions; supplies are necessarily secondary in their consideration. The bureau follows the stock market and general conditions minutely from day to day. Mr. Pliny O. Clark asked for suggestions for purchasing in individual hospitals which were far from any such bureau as that in Cleveland or New York. Mr. Guy J. Clark said he felt the solution would be a system by which the American Hospital Association would send out specifications from time to time to keep its members posted. But it would, of course, only do this if such specifications would be used by the superintendents. Mr. Clark's discussion was forceful and to the point, and it seemed that he must have "sold" to the superintendents the idea of cooperative purchasing.

Some of the members of the reception committee appointed by the Indiana Hospital Association. The spirit of cordiality that prevailed at the Convention was in no small measure due to the activity of this committee.

Transact Business at Last Meeting

At the closing session of the Convention on Friday afternoon, Mr. R. M. Bradley, trustee, Thomas Thompson Trust, Boston, Mass., was scheduled to read a paper on "An Unexploited Source of Money for Hospitals and Other Organized Work for the Sick," but owing to Mr. Bradley's absence from the session on account of illness, his paper was read by title only. In his paper, which will be printed in full in a later issue of THE MODERN HOSPITAL, Mr. Bradley began by pointing out that while service in the hospital is becoming more specialized and therefore more expensive, the old service is also becoming more expensive. We therefore hear calls for public control of institutions for the sick, state subsidies, etc. While these may be encouraged by demagogues and self seekers, yet it is plain that there is a maladjustment between the people and the service that they should receive.

The ordinary citizen feels a natural repugnance to the charitable and semi-charitable methods which are now in use. The fundamental trouble, Mr. Bradley feels, is that nursing and hospital work were organized originally to aid the pauper classes and are still conducted along those lines. Today the policy has been modified into the "pay what you feel like"—but this is a failure both morally and financially. Meanwhile we find actual service becoming less and less efficient in its application to large portions of the people. The remedies suggested are a more extended resort to the government and the taxpayer, and greater contributions from the philanthropist. Either of these remedies, Mr. Bradley feels, would be worse than the disease. The true way out is to expect in this as in any other business enterprise, financial support from the consumer. The citizen wishes to pay for the service here as he does for the benefits from a great university. To enable him to pay, it is simply necessary to recognize it as emergency service and finance it accordingly, on the benefit payment or insurance basis.

Financial Support from Consumer Not a Dream

"This is no pipe dream," says Mr. Bradley. "It is done for nursing by the Metropolitan Insurance Company for some of the needs of our very poorest out of their pockets. It has been done for years in some countries by nursing benefit payments for associate members that cut the ordinary fee in two for such members, at the expense, one of the founders told me, equal to the cost of a couple of dozen or so drinks per man. The same thing can be done here."

Mr. Bradley's advice for starting the system was, "Get your system going and you will soon enough find where it comes out in practice. Don't worry if you don't get many buyers at first. Put your cost accountants at work and find out what is the reasonable cost of every piece of service you do, and charge for it. Show what it will cost with benefit payments and without. Then if there is trouble, you will be able to show what your benefit payments can do. This kind of dealing with Mr. Ordinary Citizen will be better for his soul, and he will respect and like you all the better for it."

The remainder of this meeting was devoted to the business of the Association. Reports were received from a number of committees, including the committee on constitution and by-laws, the auditing committee, and the nomination committee. The committee on constitution and

by-laws recommended the creation of a new class of members, namely, associate institutional members; the inclusion of the term "life members" in the constitution, and the dropping of the committees on local arrangements and on time and place.

Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill., read his report as treasurer. This report showed total receipts $42,280.78 and total expenses $36,301.98, leaving a balance of $5,978.80. These figures do not include the life membership fund, which now amounts to $1,504.64.

Dr. George O'Hanlon Now President

During the coming year Dr. George O'Hanlon, medical superintendent, Bellevue Hospital, New York City, will serve as president. Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill., was named president-elect.

Although nominated and elected as first vice-president of the Association, Dr. A. C. Bachmeyer, because of special obligations to which he is committed for the coming year, declined to serve. President O'Hanlon later announced that he had prevailed upon Dr. Malcolm T. MacEachern, superintendent, Vancouver General Hospital, Vancouver, B. C., to serve for another year in the capacity of first vice-president. Dr. H. W. Hersey, superintendent, New Haven Hospital, New Haven, Conn., was elected second vice-president, and Miss Harriet S. Hartry, superintendent, St. Barnabas Hospital, Minneapolis, Minn., was elected third vice-president. Although now president-elect, Mr. Asa S. Bacon will continue as treasurer of the Association during the coming year. Mr. Richard P. Borden, Union Hospital, Fall River, Mass., and Mr. Daniel D. Test, superintendent, Pennsylvania Hospital, Philadelphia, Pa., were chosen trustees.

A group of prominent hospital social workers on the steps of the Hygeia Spring.

The following committees were also named to serve during the coming year:

Committee on constitution and by-laws: Richard P. Borden, Union Hospital, Fall River, Mass.; A. O. Fonkalsrud, superintendent, St. Luke's Hospital, Fargo, N. D.

Committee on legislation: C. G. Parnall, M.D., medical director, University Hospital, Ann Arbor, Mich.; Paul H. Fesler, superintendent, State University Hospital, Oklahoma City, Okla.; F. O. Bates, superintendent, Roper Hospital, Charleston, S. C.

Committee on nominations: D. L. Richardson, M.D., superintendent, Providence City Hospital, Providence, R. I.; Charles F. Diehl, superintendent, Hospital and Dispensary for Deformities and Joint Diseases, New York City; Margaret Rogers, superintendent, the Jewish Hospital, St. Louis, Mo.

Committee on membership: Walter H. Conley, M.D., medical director, Metropolitan Hospital, New York City; Charlotte Jane Garrison, superintendent, The Sunny Crest Sanatorium, Dubuque, Iowa; C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.

Dr. A. K. Haywood, Montreal General Hospital, Montreal, Quebec, was also named as a member of the outpatient committee of the Association.

THE SECTION MEETINGS

The dispensary ought not be regarded as an institution by itself alone, said Mr. Michael M. Davis, Jr., of the Committee on Dispensary Development, New York City, in speaking on "City-Wide Cooperation between Dispensaries," at the Section on Dispensaries, Wednesday at 10 a.m. There is urgent need for some systematic plan of cooperation among the different out-patient departments and dispensaries of a community. This is particularly true in a large city, where there are hundreds of such institutions.

For instance, the standards and methods of one dispensary should be available for the information and instruction of others. Conditions differ, and medical, administrative, or social service methods in no two places are quite alike. Consequently some organization which promotes interchange of information among dispensaries would be very helpful.

Formulation of approved methods or of standards, clinic, administrative, social, is another important function of a central organization. It is hardly necessary to point out the great need, not only for having standards but for encouraging all existing institutions to live up to them.

The Associated Out-Patient Clinics of New York City have for nine years (with some intermission during the war) provided a means of interchanging information on dispensaries with sections of physicians meeting in each of the chief types of clinic. Through these sections and committees there have been formulated joint standards.

The recently formed dispensary Committee of the Hospital Council in Cleveland is an example of a similar movement.

A good deal has been said of the evil of dispensary "rounders," patients who enjoy being treated in as many clinics as possible. Very little has been done to study the actual extent to which this is a problem, but a few years ago in Boston studies were made which indicated that the proportionate number was very small, two to five per cent of the persons treated. A much more serious evil to the patient, and in a way to the dispensary itself, is the apparently haphazard selection of places for treatment as made by patients. The convenience of being treated in one's neighborhood is very great, yet patients who live within a quarter of a mile of a very good clinic often are found in a distant dispensary. A plan of districting has been proposed as the remedy for this evil and for the evil of "rounding," but the obstacles to a rigid districting are very great, particularly in the matter of teaching clinics.

The real solution of the problem seems to be a plan of cooperation between the largest and best equipped dispensaries and the smaller clinics, by which each would do the work for which it was fitted. Though difficult, this would result in economy and efficiency.

Other problems of cooperation among dispensaries might be mentioned, e.g., financial, establishing some degree of uniformity in fees charged dispensary patients for admission, medicine, x-rays, etc., so that the rates will be more or less identical for similar types of service; aiding

in securing doctors and non-medical personnel for dispensaries by acting as an information bureau and clearing house for learning of those who want clinic work and turning their names over to the institutions which have signified their need for more helpers.

Whether one further plan of cooperation—namely, a joint attempt to aid the dispensaries of a city in financing themselves—is practicable, is perhaps worthy of consideration also. Nowhere has there been a city-wide campaign for dispensary service. The Boston Dispensary has conducted two successful campaigns raising considerable sums for annual maintenance, but a joint effort by a group of dispensaries would be still more impressive and still more educative to the community as to the nature and the need of dispensary work. Perhaps such a joint undertaking lies somewhere in the near future of one of those communities which has already the habit of raising money by city-wide canvassing.

Dispensary Needs of Small City Discussed

Dr. Davidson's paper dealt with "Dispensary Needs of a Small City and How to Meet Them." As being more illuminating than a theoretical discussion of dispensaries, Dr. Davidson described the founding of a dispensary in one of the three hospitals in a city of about 70,000 inhabitants, about one hundred miles from Chicago. A dispensary, as most hospital people feel, is an indispensable part of the hospital. And a dispensary must be founded on definite knowledge of conditions, needs, and methods of meeting them.

About four months ago when the dispensary was being considered certain steps were taken. First, a survey of the other institutions was made. There were no dispensaries nor was there any health conservation work carried on by the city government. There was, however, a state clinic conducted once each month especially for orthopedic cases. The general opposition of private practitioners against state medicine was directed also against clinics. The next step was to secure information as to the mortality rate. This was quite low due probably to high war-time wages and good living conditions.

A group of Catholic Sisters from the Pittsburgh hospitals, at Spring No. 3. They represent the Mercy, St. Joseph's, Pittsburgh and St. Francis Hospitals.

Associations Give Unanimous Support

Next, a meeting was held with representatives of the three active associations of the community, and here unanimous support was given to the project. It was also decided at this meeting that a survey be made by the visiting nurses, of the poorer districts of the city. It was found that although the families had not as yet suffered much from undernourishment, yet they were cutting down on their milk consumption. It was arranged therefore to buy milk and sell it at a very low cost at the various playgrounds.

It developed, then, that there was a very real need for an out-patient department for sick babies and children.

Good newspaper publicity was secured and two rooms having been fixed up for temporary use, the first clinic was held. It was a great success. It was well attended and the staff members of the hospital, even those who had been doubters before, were very much pleased. The second clinic was an overflow meeting and plans were started for a movement to larger quarters.

Physicians began demanding other special clinics and so, after the success of the first one had been established, others were started. Among them were: psychopathic, prenatal, eye, ear, nose and throat, medical, surgical and venereal clinics.

So far the work has been all free of charge but this of course involves the question of how it is to be financed. The hospital will probably either make an appeal to the public for funds, or put this work into the hands of the federated charities.

Dr. Emerson Speaks at Administration Section

Dr. Haven Emerson stated in his address on "How Hospital Records Can Contribute to Health Protection," at the Section on Administration, Wednesday at 2 p.m., that as individual physicians are licensed so will the collective medical service of the hospital be licensed. As time goes on the hospital will more and more be required to give an account of its contact with its patients, and to operate on certain standards of location, equipment, and administration.

The hospital is a private institution filling a public need, and in the future it will fill a public need to an even greater extent because the future of preventive medicine depends on the hospital laboratory and dispensary facilities which the public will supply. Are the hospitals fulfilling all the functions now expected of them in the preventive aspect of medical practice?

Up to the present time, the information given out by hospitals, with a few exceptions, has been dry and valueless—reports of births and deaths, and to some extent, diseases, preventable, communicable, and occupational. Public health has moved too rapidly to be served by these figures. We no longer wait for the death rate to betray an epidemic, we go into the homes and search for the sick at the first suspicion, and put them if possible in isolation. What would be the greatest single addition to the material upon which health protection is based? According to Dr. Emerson, abundant, prompt, accurate data on the existence, and sources of all diseases.

In the matter of organization there might be a central office, preferably in the bureau of vital statistics in the city where uniform reports would be received from all hospitals.

Must Know Sum and Character of Sickness

"Before we can claim to be developing or even protecting health," continued Dr. Emerson, "we must know the sum and character of human sickness. Our first and best and perhaps our last source of information will be the organized medical service in shops, the hospitals, and dispensaries, the sanatoriums, convalescent homes, and domiciles of the insane, the children, the paupers, and those great institutions now infiltrated throughout the community, the visiting nurse associations, whose experience and records offer often a greater range and bulk of material than the larger hospitals of a city or state all combined.

"It has been the story in this country that most of the permanent constructive progressive movements in public health have come from private initiative and later have been assimilated into official policies and administration, and later still have been so approved of as to become incorporated in the sanitary law of the community. It is my suggestion to this body that you authorize a committee on hospital morbidity reports whose duties shall be at least to enlist the cooperation of some organized hospital group, such for instance as that represented by the Cleveland Hospital Council, to the end that uniform daily reports of admissions, discharges, transfers, deaths, and changes in diagnosis of all hospitalized patients be reported at a central point, and there be tabulated and issued at least once a week for the information of the public officers of health and of the practitioners of medicine, and if possible be printed currently in the public press."

In the discussion of Dr. Emerson's paper, Dr. Howland of Peter Bent Brigham Hospital, Boston, said that everyone must subscribe to every word that Dr. Emerson had said. Concerning the completeness of records it is of course necessary to have notes of the end result of the patient's treatment. These are obtained by the follow-up done at intervals of every six months to a year or two years. When attempting to follow-up patients it is often found that they have disappeared from the neighborhood in which they lived and cannot be traced. This difficulty may be obviated to a large extent if, on the admission history blank, there is noted the exact initials and address of the physician recommending the case, and if the patient is also asked to name some permanent business address at which he may always be reached.

Dr. Sutton Emphasizes Rural Shortage

Dr. Sutton, Zaneville, Ohio, spoke on the shortage of physicians as well as nurses in rural districts. He stated that the average age of rural physicians in the state of Michigan would be over sixty years. He pointed out that unless some direct efforts were made to supply rural communities with medical facilities, undoubtedly the state would take steps to do so. Mr. Chapman, Mount Sinai Hospital, Cleveland, pointed out that in the end the administration of the hospital must see to it that proper records are made, for if the matter is left to the individual physician or house officer who has no power of enforcement, the attending physician will very often postpone, under pressure of other things, the noting of necessary data.

Reporting of Morbidity Statistics Suggested

On the motion of Dr. Bachmeyer, made because of suggestions from the audience, it was voted that the committee on forms and records be instructed to communicate with some central body interested in community disease to devise a method of reporting daily to the board of health in its community all the types of disease received by all the hospitals in that community every twenty-four hours. In the discussion Mr. Chapman felt that the Cleveland Council would be willing to undertake such an experiment in order to show the country the value of transmitting to the local health officer information as regards impending epidemics and other diseases in which the public health might be safe-guarded sooner than is now possible.

Vital Statistics Hospitals Should Collect

In his paper on "Vital Statistics that Hospitals Should Collect and Publish," Dr. Nathaniel W. Faxon, Assistant Resident Physician, Massachusetts General Hospital, classified hospital statistics into three groups, as statistics dealing with (1) The admission and discharge of patients, age, sex, race, occupation and similar facts. (2) Those dealing with the medical or surgical history of the patient. (3) Financial statistics, including a detailed account of the receipts and expenses of the various departments, and the cost per patient per day.

Statistical study of hospital data is indispensable in estimating administrative programs. The fields of service are (1) The advancement of medical and surgical science. (2) The aiding of public health administration. (3) The assistance of hospital management.

To serve a useful purpose in these fields, hospital statistics and reports must fulfill three distinct conditions. They must be statistical, or scientific and complete; they must be arranged for development and interpretation; there must be some measure of efficiency of service. It is obvious that hospitals of different types cannot entirely compare statistics, yet they can be gathered with the same general principles in mind. A general hospital, which is the type treated by Dr. Faxon in his paper, should collect complete statistical data on each case, arranging these data so as to be readily accessible for use, and studying them so as to determine the efficiency of treatment and management.

Should Not Be Too Brief, Says Dr. Faxon

Dr. Faxon went on to make certain requirements for statistical histories. They should not be too brief. One way to overcome this difficulty is to have a standard form or outline which must be followed in taking a history. Next is a method of tabulation. The most generally useful and flexible systems of mechanical tabulation are those of the Hollerith systems, a modification of which has been made by the Powers Accounting Company. By their use a large number of data may be easily transferred to small punched cards, and any conceivable grouping of data obtained through the mechanical sorting and recording machines. No hospital can afford the labor and expense of hand tabulation, and no card catalogue can foresee the questions of investigators. Therefore, mechanical tabulation is the best means yet provided. One important point, in order that the comparison may be made between hospital records, is that a common nomenclature of disease be adopted. Most hospitals now follow the International Classification, although probably the ideal code has not yet been developed. A hospital may measure its efficiency only by a study of its end results, and a comparison of these from year to year, as well as a comparison with those of other hospitals. This follow-up work should be a part of the hospital statistics.

The publication of hospital statistics represents the same fields of service as are represented by their collection. To make comparison between hospitals possible it is desirable that a standard for publication should be developed, and also a standard for their collection. There are two methods of determining such a standard—one by appointing a committee, representative of the whole country, to consider the question, another by turning over the matter to the state medical societies. Such common methods of collection and publication are essential if hospitals are fully to serve the common good.

There was no discussion on the paper of Dr. Faxon, but on motion of Dr. Holland it was voted that the trustees be asked to assign to the committee on forms and records the task of presenting a model hospital report which might become the standard form used by members of the Association.

There was general discussion of the report of the special committee making a study of the recording of hospital

work and postponement of further discussion until the evening session. On motion of Dr. Faxon a sincere vote of thanks was given to the committee for the monumental work done by it, which work should mark an epoch in hospital progress.

Miss Thornton Analyzes Social Work

The program of the Section on Social Service, Wednesday evening, September 14, was a discussion of the social service department in its relation to the medical care of patients and to the hospital administration. These two relationships are viewed as fundamental in the report of the committee of the American Hospital Association, which surveyed social service departments. The main paper of the evening was prepared by Miss Janet Thornton, who is associated with the Committee on Dispensary Development in New York City, and was read by Miss Mary Antoinette Cannon, secretary to the Committee on Training of the American Hospital Association, which has been appointed to study and prepare a curriculum for the training of hospital social workers.

Miss Thornton's paper is basic in its analysis of activities and declaration of principles by which a medical institution serves its purpose in the community. Its very title—"The Place of Social Service in the Administration of Hospitals and Dispensaries, or the Relationship of Hospital Social Service to Other Hospital Services," indicates at once the scope of her subject matter, and its significance both to hospital administrators and to hospital social workers. She inquires into the purpose and conduct of medical institutions and says of the social service department, "Social service rightly understood and practiced is an integral and specialized part of the hospital's medical service. It is not a generalized hospital service; neither is it a generalized community service injected from without, nor a graciousness contributed by a ladies' committee."

It is almost impossible to summarize Miss Thornton's paper, which is so carefully woven together—to tear it apart is to misquote. One pitfall of the social service department may be mentioned, but all else in her paper —the real analysis which she gives, must be left in the pages, which will be printed in entirety in a later issue of THE MODERN HOSPITAL. She says "The most frequent and dangerous pitfall has been the attempt to make up for the many inadequacies of hospital management in other divisions of the service department—housekeeping, clinical, financial, nursing, etc., meanwhile neglecting its own proper and magnificent service."

Mr. John E. Ransom of the Michael Reese Hospital and Dispensary of Chicago, opened the discussion.

Mr. Daniel D. Test of the Pennsylvania Hospital spoke on the value of, and necessity for, a social worker as a member of the administration, in order to admit patients and determine just rates. He believes this function must be carried out by a social worker but *not* under the social service department.

Dr. M. T. MacEachern and other administrators continued the discussion, commenting on experiences they had had in their own hospitals, and unanimously insisting on the necessity of having a social service department.

Miss Riddle Presides at Nursing Section

The Section on Nursing met Thursday afternoon at 2 p.m., with Miss Mary M. Riddle, superintendent of the Newton General Hospital, Newton Lower Falls, Mass., presiding. The first subject was "The Shortage of Prospective Nurses, Causes and Remedies," prepared by Miss Nancy E. Cadmus, former superintendent of Manhattan Maternity Dispensary, New York City, and read by Miss Surrey of Peoria, Ill. Miss Cadmus said that every educational institution, except perhaps colleges and universities, is suffering now from a shortage of students. She felt that some of the reasons for the shortage of nurses were the fact that after college wage-earning could be started at once; the lack of the spirit of service in many adults making a corresponding lack in the younger generation; a reaction from the responsibility and seriousness of the war; the fact that some heads have been turned by prosperity. She felt that it was merely a matter of time until certain readjustments would be made, when people would begin to realize that success is impossible without taking some responsibility, and giving some service. She felt that the shortage was not due to conditions inherent in nursing schools.

Dr. Davidson, superintendent, Rockford Hospital, Rockford, Ill., said in the discussion that the hospital game is the same as any business—a selling game, you have to have advertisements and salesmen. No matter what the factors are in the shortage, you must sell nursing to prospective students. His board of trustees spent recently $900 in advertising in small papers, without a single reply. Mr. Davidson then hired a college woman who was a graduate of the school and told her that she was a salesman for the training school. He got names from doctors and started her out to sell the school's training. She went to see prospects and the fathers and mothers of prospects. In six weeks of work she interviewed 211 girls and in most cases the parents. Fifty per cent of the girls felt that in nursing they would have to give up so much of the normal life as compared with entering college or employment. In most cases one parent at least objected, mothers to the long hours and hard work, and fathers to the moral hazard. Nearly all objected to the three years' training. It was easy to overcome the objection to the hard work, but the three years' training was not so easy, and the hospital is now giving serious consideration to the idea of inaugurating a pre-nursing course in the high schools of the city, which would give one year of credit in the hospital. The result of the sales campaign was nine probationers in August, seven more starting in September, and fourteen signed up for next spring.

Dr. John F. Bresnahan of the Bridgeport Hospital, Bridgeport, Conn., stated that last year in his 275-bed hospital he had thirteen probationers. After a great deal of theorizing with no result the superintendent and trustees decided to attack the problem practically. They first got a well-trained woman to put the school on a basis so that it could be advertised, and the training course was decreased from three years to two years and four months. The idea of hospital work was then sold to the parents. A large advertisement was run in the newspapers of the city for two evenings, and resulted in 136 applications. The hospital then realized that it must follow these up. It had a moving picture which cost $1,300 taken of the life in the hospital. It was given a great deal of publicity in the papers, was shown in many places, finally being syndicated through all the moving picture houses. The hospital now intends to send it around to the rural districts in a Ford, and show it on a sheet hung against a barn. On the day Dr. Bresnahan left for West Baden thirty-five probationers entered the hospital. He arranged to have an intensive course, so that those who could not qualify according to education could get a certificate for two years of high school work, and thus be able to enter the hospital. After the meeting the picture was shown in the moving picture theatre. It was an attractive story of the life of a probationer entering the hospital and finally finishing her course. It gave what Dr. Bresnahan said was a very

true representation of her work and play, her troubles and joys.

Miss Mary M. Roberts, associate editor of the American Journal of Nursing, said that figures on the number of student nurses were very encouraging, showing that hospitals, many of them, were turning away applicants. This generation, she said, is a generation of individualists, seeking self-expression, and if we will show young women the broader aspect of nursing service perhaps they will find here this self-expression.

Eight Hour System Has Come to Stay

The paper on the eight hour day for student nurses was prepared by Miss MacMillan, superintendent of the School of Nursing, Presbyterian Hospital, Chicago, and read by Miss Frances, superintendent of the Children's Hospital, Philadelphia. She felt that the reasons for the eight hour day were the cheerful service resulting, the humaneness of the system, the fact that it leaves the student strength to carry on her class work better and to keep up some outside interests. Some arguments against it are that the student may misuse this extra time, but she may be guided in this as in her hospital work. The argument that it uses up too much of her energy in other ways has not been found to be true. The eight hour day is not easy to arrange but it must be accepted and handled as a necessary problem.

The paper on "The Necessity for an Adequate and Reliable Curriculum in the Training School," was read by Miss Jessie C. Catton, superintendent, Lawrence General Hospital, Lawrence, Mass., who was acting as secretary.

The schools whose ranks are best filled are those having the highest educational standards. Just as the college student chooses her college, so the student nurse is beginning to choose her training school, with respect to the educational advantages offered. Therefore the school should have the curriculum which would be attractive to women considering nursing as against some other vocation. A short well-written paragraph in the prospectus explaining the courses and showing their connection with nursing would stimulate interest. The prospectus should be of interest to parents also, and it should explain that hours are shorter and work easier than formerly. There should be well-selected illustrations, not of empty wards and class rooms, but pictures of nurses at work and at play. The prospectus should also outline the field open to the nurse executive—work in hospitals, private duty, public health—and it should emphasize the preparation for life. In the discussion, Miss Mary C. Wheeler of the Illinois Training School, Chicago, said that it was important to take care of the mechanical side, to consider the paper, the cover, and the ink. She also said that a follow-up should be made of the woman who is below age, or below the educational standard, in this way to keep the institution before her. Miss Click of the Philadelphia General Hospital, said that in the prospectus the young woman should be shown that the school would give her the education she needs to do her work in her field. Many criticisms are based on the fact that the training does not prepare her for her life work, that it is planned along old lines for the bed-side worker, and not along broader lines of service. The prospectus does not tell enough about the personal welfare of the student. The mother should be assured of the interest taken by the hospital in the student's personal health.

A paper on "A Plea for Simpler Records in Training Schools" was presented by Miss Lock, assistant superintendent of nurses, Memorial Hospital, Worcester, Mass. She stated that her plea was not so much for a simpler system, as for some system which should be clear and concise. She gave a short outline of the method used at her hospital. Miss Riddle in the discussion said that if you don't know how to keep good records, you should go to a sensible business man, and have him show you.

Dr. MacEachern in making some general remarks said he has found that with the lower age of the applicants they were able to take less responsibility. He said that the physical examination of students was often sadly neglected. In his hospital a full certificate is filled out and the student is examined by his own staff on the day of admission. He recently had to turn down two out of fifty-two applicants who had been passed by their own physicians. The school should have a high standard of health for the nurses. He also stated that affiliation with smaller hospitals had worked out well in his hospital. At the end of the session officers were elected, the chairman for the section next year being Miss Laura A. Logan, director, School of Nursing and Health, Cincinnati General Hospital, Cincinnati, Ohio, and secretary, Miss Clara E. Pound, Reid Hospital, Richmond, Indiana.

OFFER PRIZE FOR PLAY BASED ON LIFE OF FLORENCE NIGHTINGALE

Harold Newcomb Hillebrand, department of English, University of Illinois, has just been declared the winner of the $500 prize that was offered by the Central Council for Nursing Education of Chicago, for the best play of three or four acts written by an American author and based on the life, or incidents in the life of Florence Nightingale. The offer of the Chicago Council, of which Miss Martha Wilson is the chairman, was sent throughout the country on the occasion of the one hundredth anniversary, on May 12, of the birth of Florence Nightingale, and resulted in the receipt of hundreds of manuscripts. Among the plays submitted to the New York office of the Nightingale Centennial Committee, National Organization for Public Nursing, who took charge of the competition, only two showed the required dramatic conception of the life of Miss Nightingale, one signed with the pen name "Illinois," the other under the nom de plume of Ernest Brook. For many weeks the decision of the committee of judges, consisting of Mrs. Minnie Maddern Fiske, the well known actress; Miss Marylka Mojeska, now Mrs. Pattison; Miss Alice Beer, and Miss Lillian Wald, wavered between the two plays, the final award, however, being by a majority of votes given to "Illinois," the pen name chosen by the Illinois man, H. N. Hillebrand. Mrs. Harry Fielding Reid, 608 Cathedral Street, Baltimore, Md., the writer of the "Ernest Brook" play has been given honorable mention.

It is hoped by the Central Council for Nursing Education that the prize play may be put into shape to be produced in Chicago during the coming winter.

The Central Council for Nursing Education, which gave the prize for the play, was organized early in 1920, through the interest and activity of the lay boards of several Chicago hospitals each of which maintains a training school with high educational standards. Its object is to spread information regarding the nursing profession, and it stands ready to guide young women in the proper selection of a school for training and to give them any information possible. It endorses only the schools which give the highest training.

The Council, knowing the crying need for nurses all over the country at the present day, is making its endeavor to acquaint young high school girls and college women with the actual work and scope of nursing and the splendid practical training courses that may be had free of tuition fees.

ROUND TABLES NOTABLE FEATURE OF CONVENTION

WHAT CONSTITUTES GOOD SERVICE TO THE PATIENT?

THE Round Table on "What Constitutes Good Service to the Patient?" was conducted by Dr. M. T. MacEachern, superintendent, Vancouver General Hospital, Vancouver, B. C., who gave a talk on the acid test of the hospital's right to exist—the service rendered to the patient. Consequently the hospital must aim at the following objectives: (1) A good reception of the patient on admission to establish a comfortable mental attitude. (2) Prompt attention to all matters, large or small, especially small. (3) Careful examination of the patient and careful records. (4) Availability and utilization of all facilities for diagnosis. (5) Consultation as often as necessary. (6) Medical audit of medical work of the hospital by the staff. (7) Monthly report to the board of trustees.

Hospital service is of two types—personal and scientific. In the personal service the hospital must establish three confidences—that of the patient in the hospital, that of the community in the hospital, and that of the doctor in the hospital's facilities. The first thing in the personal service is the establishing of a comfortable mental attitude in the patient, which means a kindly interest taken in the patient; a quiet and attractive admitting room, with a personality to fit, preferably managed by nurses; good service in the wards, such as not allowing the patient to wait, helping him to get to bed, giving him a cold drink of water rather than a luke-warm one, etc.; the taking the place of family and friends if the patient has none, and extending a friendly hand when necessary.

Under the scientific service come diagnosis, and care and treatment. The doctor makes the diagnosis, using the hospital's facilities, and for this diagnosis Dr. MacEachern believes the hospital should offer certain facilities determined by a minimum standard. Big hospitals must offer their services to the small, for the more complicated cases, but the minimum for all hospitals should be an x-ray department, a laboratory for the simpler tests, electrocardiograph, and the best of consultation.

Nursing Service Most Important in Treatment

In the care and treatment the most important thing is the nursing service. The hospital needs well-trained nurses, with suitable personality which would include tact, gentleness, kindness, with diligent attention to little things, and with the spirit of a desire to please. They should be trained carefully in the observation of the patient, so that they can express intelligently in the records their observations. The nurse is the doctor's third and most important eye The intern should have much the same qualities as the nurse, and should be diligent in carrying out the doctor's orders. The orderly and attendant service is also important. These members of the staff must be trained, and there should be one man at their head. At the Vancouver General Hospital a regular course for orderlies is given, with an examination at the end of six months, the passing of which allows them to go on with the course for attendants. If this examination is passed at the end of one year they become attendants at an increased salary. This plan brought a better class of orderlies to the hospital.

In the pharmacy service a book should be compiled of the prescriptions which doctors most often use, so that they may be kept in stock, and may be ordered by prescription instead of necessitating the doctor's writing them out each time. The laundry service should be sufficient to give the patient good clean linen. Most hospitals have a central linen room.

In the operating service there should be the practice of having pathological examination of the organs removed to see that there are no normal ones. There should be competent anesthetists, proper examination of the patient before operation and proper asepsis. The accident service should be adequate for emergencies. Over all there should be a good executive holding conferences with the heads of departments every two weeks, a medical staff organized for staff conferences, and a board of trustees receiving monthly reports.

Definite Questions in Round Table

The round table discussion was organized into seventeen questions each of which was answered by someone specially appointed by Dr. MacEachern, and some of which were followed by open discussion. Mr. F. E. Chapman, Mount Sinai Hospital, Cleveland, spoke to the first question on "How can patient's relatives and friends be so handled by the hospital as to establish a confidence in it, and a comfortable mental attitude?" Mr. Chapman said he thought there should be machinery for counteracting the patient's antagonism for the hospital. This would include: (1) A less forbidding exterior of the building. (2) A more attractive lobby, with less white paint and no uniformed nurse in charge. (3) In the admitting room someone who can smile twenty-four hours a day. (4) Avoidance of talking about paying the bill the first thing. (5) An administrative round by the superintendent to see that the patient is satisfied. (6) Follow-up work, consisting in a card asking for the patient's reaction to the hospital, as has been done in Mr. Chapman's hospital.

The second question, answered by Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago, dealt with the type of follow-up work mentioned by Mr. Chapman. Dr. Smith also advocated the administrative rounds of the superintendent, and the sending out of a form after the patient has left, asking for his suggestions. This work has been successful at Michael Reese, and has been of real value. Dr. Smith also would have a member of the dietetic department visit the patient to see that the meals are satisfactory.

The third question was answered by Dr. George Stephens, superintendent, Winnipeg General Hospital, Winnipeg, "How can the medical staff be made to take more interest in the clinical work of the hospital?" There is no one method, said Dr. Stephens, but in his hospital they have tried a successful experiment. Group meetings are held in the form of a lunch twice a month. Here clinical cases are brought up and absolutely free discussion is held, and the members' unsuccessful, rather than successful, cases are discussed. These meetings have a decided influence in increasing the consultations on private cases, and fostering a good spirit among the staff.

One Nurse to Two Patients, Says Mrs. Clarke

The question of the "Proportion of nurses to patients in a general hospital for pay and non-pay cases, and having an eight hour service," was answered by Mrs. Ethel P. Clarke, director of School of Nursing, University of Indiana. The proportion is one to two, according to Mrs. Clarke, eight to twenty-five according to another superintendent, and one to two, two and a half, or three, according to Dr. MacEachern. Dr. Joseph B. Howland, Peter Bent

Brigham Hospital, Boston, stated that the best way to keep track of infection in postoperative cases, is to have a separate file, marking the cards "postoperative," and filing them in this place.

Mr. Pliny O. Clark, superintendent, Presbyterian Hospital, Denver, answered the next question by saying that the orderlies, cleaners, maids, etc., should be under their respective heads in several respects, such as, hours of duty, etc., but should be under the head nurse of the ward in general matters. The nearest to perfect service is maintained if the head nurse and the head orderly can work together. The question of "Should operative cases, other than emergency, be kept long in a hospital before operation?" was answered by Dr. C. K. Haywood, superintendent, Montreal General Hospital, by saying that they should be kept in the necessary length of time. This necessary length of time can be determined only by the type of case. Ordinary preoperative procedure should be carefully followed, and a careful examination made of the patient's chest. Dr. MacEachern answered the next question on "What are the essential requisites to satisfy the patient in the matter of food?" Although there were murmurs, amounting almost to a roar, that it could not be done, Dr. MacEachern said that there were three essentials—buying by an expert, cooking by an expert, and serving in an expert way.

Medical Men Responsible for Records

Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, in answering the next question, said that medical men should be definitely responsible for completing medical records in every case whether a private or ward patient. Some hospitals have a form which they require the doctors to fill out within twenty-four hours. If the doctors dislike to put down certain data concerning the patients a code could be used, or some method by which the patients' names would not appear could be found if necessary. It was the general opinion that if the records were kept by interns, the doctors should check them up afterward. Mr. Bacon suggested that doctors might use the dictaphone when they would not sit down and write their records. One superintendent stated that interns took all the histories in his hospital, and that it worked very successfully. They, having more time than the attending physicians, got fuller histories, and also on account of giving them this experience there were more interns anxious to come to the hospital.

Miss Mary M. Riddle, superintendent, Newton General Hospital, Newton Lower Falls, Mass., said that undergraduate nursing service would be more satisfactory in the larger hospitals if the applied nursing service were not separated from the instructional division, i. e., with two departments. Miss Riddle said that instructors in technic should have access to the wards at all time, in this way keeping track of the practical work. She felt that the two sides must be thus correlated.

Technician Can Be Secured Says Dr. MacEachern

Dr. MacEachern said that technicians could be secured who were capable of doing x-ray, laboratory and case record work combined, because he had done it successfully in his hospital. He answered the next question also on "Should all postoperative cases be immediately segregated?" by saying that they should be as far as possible.

Dr. M. T Morrill, Shreveport Charity Hospital, Shreveport, La., said that the board of trustees could be impressed more thoroughly with the crucial importance of the patient, rather than the monetary side of the hospital, by the enthusiasm and interest of the superintendent. The board will reflect his spirit. At the board meetings the superintendent should not hasten to tell them his troubles, but should give them a detailed financial report which they could take home, and then talk to them of the medical complaints heard and gradually educate them along that side.

Monthly Report Issued Like Annual Report

The next question on "What should constitute a monthly medical report to the board of trustees?" was answered by a superintendent who said that in his hospital a monthly report is issued in the same form as the annual report. It is statistical, and it is textual, for the superintendent writes reports on the important work done by the various departments. This is mimeographed, and given to the trustees.

Dr. MacEachern answered the next question on "What cases should be segregated from the general wards of the hospital other than the infectious?" naming typhoid, tuberculosis, skin diseases which were contagious, or all if possible, sore throat, erysipelas, anterior poliomyelitis, mental, alcoholic, delirious, and noisy cases.

The question, "Should the private laundry of the patient be done in the hospital laundry?" was answered by an entirely unanimous "No."

Person Giving Out Information Important

Dr. Morrill spoke on the last question, "What is the best way to have satisfactory information given out to relatives and friends regarding the patient's condition?" He said the first thing was getting the information for the relatives. The solution to this in the large hospital was the private branch exchange in each ward, if the hospital could afford it. In the small hospital the superintendent of nurses would be in touch with all the patients, and would know of any changes. The more important thing, however, is getting the information to the relatives. This is solved by having the right person at the telephone, one who will not say nonchalantly, "Oh, he died last night at ten o'clock." It is important for this person to have good judgment and a pleasant voice. A pupil nurse should not be put here because there is no other work for her to do at the moment.

HOSPITAL CONSTRUCTION

The Hospital Construction Section of the American Hospital Association met on Wednesday at 10 a. m. The meeting was called to order by the chairman, Dr. George O'Hanlon, superintendent of Bellevue and Allied Hospitals, New York City.

The chairman stated that the section had met twice in the last year for the purpose of preparing a program, but that it was decided to do away with prepared papers, and to make this year's meeting purely a round table.

The session was very well attended, and the reason became apparent when the chairman asked those present to indicate by rising if their institutions contemplated building within the year. At least 150 persons so indicated.

The question of cost was probably the one in most minds, and it was very thoroughly gone over by Mr. Edward F. Stevens, the well-known Boston architect. While he said that it was a difficult problem at this time to determine the cost per cubic foot, yet, from his experience, building was materially lower than two years ago. Mr. Stevens and Mr. Chapman, of Mount Sinai Hospital, Cleveland, Mr. Richard E. Schmidt of Chicago, Mr. Daniel D. Test of the Pennsylvania Hospital, Philadelphia, and Dr. Conley of the Department of Public Welfare in New York City, gave concrete examples of estimated costs of various types

View of the approach, park and formal gardens from

of hospital construction, and the consensus of opinion for the experience of these men was that construction can be accomplished today for 20 per cent below the peak of eighteen months ago.

Mr. Frank E. Chapman was to have prepared a paper on the subject of hospital flooring, but instead he prepared a questionnaire which will be sent to the members of the American Hospital Association. He explained to those present just what he hoped to accomplish with this research. It will give a complete résumé of the individual experience of many of those present at the Convention with practically all types of flooring, including cost of installation, maintenance, noiselessness, sanitary quality, durability, etc. Mr. Chapman also presented a vivid picture of his experience with plaster at Mount Sinai.

Incinerators Should Be Done Away With

Mr. Pliny O. Clark, of the Presbyterian Hospital, Denver, Colo., brought forward the question of the installation of incinerators in the hospital. This question was very thoroughly gone over, with the weight of opinion on the side of doing away with incinerators altogether, and depending upon other methods of disposal. The reason of the opinions so given is founded upon the great waste which cannot be controlled. Where incinerators are installed the plan in the larger hospitals is to have an inspector of waste watch all the material consigned for consumption.

DEPARTMENTAL PROBLEMS

Mr. Bacon in preparation for his Round Table on Departmental Problems had collected a number of questions which he did not assign to any particular person, but asked for discussion from the floor. The first question was "Should all patients receive a careful examination on entering the hospital?" The medical staff being split up into so many specialties it seems absolutely necessary, Mr. Bacon said, for the patient to have this examination, although very often he does not get it. The patient should be entitled to know all his defects. According to a show of hands the majority of superintendents present did not require it. Many have found objections on the part of patients to having physical examinations made by interns. In some cases a private patient could only have the examination by order of the attending physician. Dr. MacEachern stated that undoubtedly every patient should have this examination, and a personal history should be taken. Another superintendent stated that he had made it an absolute rule that there should be an examination by the intern within twenty-four hours, and in twenty years' experience he had had no objection from patients. He brought out the point that you could get better interns if you gave them this experience. Dr. MacEachern said patients sometimes came into the hospital with infectious diseases, making the examination doubly imperative before they were admitted to the general ward. In his hospital he has an admitting ward, so that patients are not put in with others until the examination has been made. In one 100-bed hospital operations which were unnecessary were stopped in several cases by this examination, and in this way, also, undesirable doctors were eliminated from the staff.

The second question on "How can the hospital in a small community be made of the greatest service to physicians practicing in the rural districts?" was answered by Mr. Pliny O. Clark, Presbyterian Hospital, Denver, who quoted Dr. Sampson's experiment in the state of Iowa of sending out clinics to the remote districts. For example, tonsil and adenoid clinics would be sent out, not only for diagnostic but also for operative purposes. A small hospital in a town of 70,000 reported that it was planning to carry out Dr. Sampson's idea by forming an associate staff of the physicians from the small towns near, for whom monthly clinics would be held by the hospital's regular staff. Patients may be brought in to these clinics and the hospital hopes in this way to attract the younger medical students to the rural districts where they are so much needed.

The question "Should the superintendent of the nurses' school be under the superintendent of the hospital?" was greeted with much laughter, and a unanimous "Yes."

Small Hospital Should Have Laboratory

Much discussion was brought out by the question of "how to install a laboratory in a small hospital." It was the general opinoin that the small hospital should attempt to have a laboratory to the extent of its means. One laboratory was supported by fees from patients, all who stayed in the hospital twenty-four hours paying a fee. Dr. S. G. Davidson of Rockford Hospital, Rockford, Ill., he got actual prices from laboratory supply companies and found that he could start one for $1,500. He then hired a pathologist, which "scarce animal" was attracted by a salary of $3,500 a year, and 50 per cent of the profits, and they together bought all the glassware, utensils, and reagents for $1,588. The laboratory is complete enough for a 300-bed hospital. Dr. Davison decided that for a smaller hospital $700 would buy sufficient equipment for all necessary treatment. He gives the use of the laboratory to the doctors free of charge, and the fifty

the main entrance of the West Baden Springs Hotel. By a Staff Photographer.

cents a day fee from patients finances the laboratory without trouble. A small hospital reported that it shared a pathologist with several other hospitals, paying him a fee of $50 a month.

The question, "Should autopsy work be encouraged?" found a large majority in favor of it, and doing it in their hospitals. Mr. Bacon said that in some months in his hospital the average was 70 per cent autopsies. A meeting is then held every Saturday to review the autopsy work, and it is found to be of great benefit. Little opposition has been met from relatives and friends in this hospital.

Shifting Among Superintendents Detrimental

The question, "Should the superintendent sign a long-term contract?" was met with murmurs of dissent. Mr. Bacon, however, reminded them that there had been unrest among superintendents, as well as among other wage earners, and much shifting had been done, which has been detrimental to hospitals. If the superintendent sticks on the job for a long period of time, he can accomplish more, and he wins the respect and confidence of his community. Mr. Pliny O. Clark brought up the point that the superintendent does not get the most out of his job if he leaves too early. In the first place, he does not get the credit for his work, because his plans have not yet matured, and in the second place, there is a certain amount of satisfaction in surmounting obstacles which seemed sufficient cause for resigning. One superintendent said he employed his personnel on the basis of their former length of service; another gives a bonus of $100 to the employee when he has been there five years.

The average salary paid to laundry employees was about $55 a month, with meals and no rooms; in one case $14 a week with meals, in another $45 a month and full maintenance.

There was little discussion of the question, "How to make the best use of by-products of the hospital?" Mr. Bacon made one suggestion, that of putting new rubber in the center of draw sheets and using old rubber on the sides.

Majority Have Central Linen Room

The majority of hospitals seem to handle their linen through a central linen room, although some said that they were successfully cutting out some labor and expense by sending direct from the folding tables to the wards. Dr. MacEachern said that in his hospital there was a loss of linen which could not be accounted for even by having a central linen room. He employs one person to see that stains are removed before they are set by sterilization. The linen in most hospitals is not counted before going to the laundry.

The problem of controlling ward visitors in a general hospital was discussed by Miss Mary L. Keith, superintendent, Rochester General Hospital, Rochester, N. Y., who has installed a system by which ward patients are allowed two visitors in the afternoon and one in the evening. Visitors' cards are issued by a service bureau at the door. It was found to be so satisfactory that it has been extended to the private rooms, where it has also worked well.

Mr. Bacon stated that in his hospital babies in the maternity ward were admitted as patients with regular admission cards, because it takes as much time and is as expensive to care for a baby as for a patient. The baby is then put under the pediatrician, so that medical attention may be had if necessary. He is classed as a free patient. It was found that all were counting babies as patients, which is an important point in making out annual reports. For this reason a motion was unanimously passed that the convention approved of this.

Mr. Bacon Defines "Hospital Patient"

The question then came up, "What constitutes a hospital patient?" to which Mr. Bacon replied, anyone who has been admitted, assigned to a room and received medical attention. X-ray patients are counted as out-patients. The majority were in favor of not allowing tonsillectomy cases to leave the hospital on the day of the operation. Returning to the question of a hospital patient, Mr. Bacon said he classed relatives and friends remaining in the room with patients as "attendants" and charged them $4.50 a day.

The next question was, "What should be the relation between the chief dietitian and the head nurse in the question of serving?" It was the opinion of one superintendent that just as any specialist comes into a ward for his special work, so should the head dietitian. Dr. MacEachern said that his head dietitian comes to the meeting of the heads of departments where each brings his problems, and in this way cooperation with the nurse is furthered. The average salary of dietitians was decided to be $150 a month.

The great majority of hospitals represented allow their interns to be the first assistants in major operations. In one or two it is allowed after a certain period of time. In several hospitals in which it was not permitted it was because the associate surgeon was the first assistant. It was stated that in Pennsylvania, Illinois, and New Jersey the board of medical examiners requires that interns be first assistants.

Although no one was using the cafeteria system in a

sanatorium where there were mostly ambulatory patients, it was agreed that this was entirely practicable if there were someone to supervise what the patients chose to eat.

Menus Save Waste in Food

The last question was, "Does anyone send menus around to the patients allowing them to choose as if they were in a hotel?" The superintendent of a 230-bed hospital stated that he was doing so in the private rooms, and then he found it saved money, for each patient then selected only what he wanted to eat. In a large hospital in Pennsylvania the system was working successfully of sending a food carriage around to the bedside, where trays were made up according to the patient's choice.

HOSPITAL ADMINISTRATION

The Round Table for the Discussion of Administrative Problems was held at 8 p. m. Wednesday, September 14. Dr. A. C. Bachmeyer, Cincinnati General Hospital, was chairman of the meeting; Dr. Parnall, Michigan University Hospital, secretary.

The session occupied its time largely with a discussion of office records, the use of the system of records which has been suggested as standard by the American Hospital Association committee appointed for this purpose.

Mr. Chapman made a comparison of the financial records of industrial plants and those of hospitals. He made a statement that no industrial plant would attempt to function without proper financial records, but that there were probably only about 10 per cent of the hospitals of the United States and Canada which really knew their own financial condition, or had proper inventories of their own assets. Mr. Chapman suggested that tabulations of charges to patients be kept; that charges be sent to the office each day from every department of the hospital; that in the matter of purchasing it was necessary to markedly differentiate between giving orders and purchasing material, and that purchases should never be made without consulting the most recent quotation sheet; that while a quotation sheet was simply comparative, it showed not only the market prices but told the vendor that the buyer was on the job.

Purchase Orders a Check Said Mr. Chapman

Purchase orders, Mr. Chapman said, were a definite check on the hospital personnel, and that these same purchase orders compared with invoices and receipts for goods were the evidence to check up all purchases.

As to the internal requisites, neither the superintendent, the nurse, nor the dietitian, nor any department head, no matter how efficient and conscientious he may be, should be allowed unlimited authority to draw from storerooms.

The inventories recorded should be perpetual, and care should be taken that all purchases are charged to the proper month on this record.

A comparison of the pages of the purchase register should show the right time of year to purchase goods. This purchase register is necessary even when the amount of funds expended is small, and will give information when checked with market prices to make a background for purchase action.

Dr. John F. Bresnahan, Bridgeport Hospital, Bridgeport, Conn., took up the question of professional service reports. The American College of Surgeons has introduced proper forms, but they are not yet perfected. Each hospital will have to change and adapt them to its own needs, and eliminate the expense of unnecessary printing. We know, first, that we must have a routine history. It is a question if, when we have a competent committee to supervise these histories, it would not be better to use blank sheets, thus saving the multiplication of forms.

This statement brought out considerable discussion from the floor, questioning whether the blank sheet or the sheet containing leading questions was the most valuable. The consensus of opinion seemed to be that where histories were well supervised the blank sheet might be all that was needed, but where thorough supervision was not possible the sheet containing leading questions should be used.

Following this, Dr. Bresnahan and Dr. Bachmeyer spoke on the use of graphic charts for the analysis of institutional activities. The round table closed with the election of Dr. C. G. Parnall as chairman and Dr. Nathaniel W. Faxon, assistant resident physician, Massachusetts General Hospital, as secretary for the coming year.

DISPENSARY PROBLEMS

The first question which was brought up at the Round Table on Dispensary Problems, conducted by Mr. J. E. Ransom, Michael Reese Dispensary, Chicago, was, "Can dispensaries have a larger number of physical examinations than at present?" The practice of giving them does not obtain in many dispensaries. Dr. Henry, St. Louis, said that anyone must realize that there is as much reason for the physical examination in the out-patient department as in any place. He did not know whether it could be worked out practically. Someone else voiced the opinion that it was more important to have such an examination in out-patient departments, especially for the treatment of syphilis, because of the impression on the patient. He is more likely to follow out the treatment if he has had an examination. In the teaching hospital it is not difficult to have the examination made, but in the non-teaching hospital physicians often refuse to do it, and the only solution is the use of interns.

Patient Has Complete Physical Examination

Dr. Simon Tannenbaum of the Jewish Hospital of Philadelphia, which has a dispensary treating from 1,500 to 2,000 cases a month, says that every patient there is referred to the medical department for complete physical examination, which is made out on a prepared form. This form is then sent to the department to which the patient is referred. Since the system has been inaugurated the attendance at the clinics has doubled. Twenty minutes is given to each patient. Mr. Ransom believed that this was practical with reference to certain types of patients, but he knows that in his dispensary some patients would leave if a physical examination were suggested. Mr. Michael M. Davis, Jr., said that in genito-urinary clinics with which he has been connected, it has been tried, but found to take too much time. It also seemed necessary to have specialists there for treatment of defects found, eye, ear, etc., which was impossible. So the system was tried of having a complete examination made of the syphilis patients by the doctor who was going to treat the case. This added ten minutes to the necessary time for each patient. It was thought to be very worth while, and although it added to the work of the medical staff, they felt it very beneficial. Mr. Ransom said that in some dispensaries a cursory examination was made by a medical man at the admission desk. He believes that this should be done, as many diseases, other than those for which the patient is coming to be treated, will be found.

The next question was, "Do physicians and attendants at the clinics have a hospital connection?" In New York City, according to Mr. Davis, in dispensaries which are

out-patient departments of hospitals, some physicians have hospital connections. In larger clinics, however, few have except the chief, who is an "attending" or whatever is the title given. The others have hospital posts which give honor but few privileges. Those who have hospital connections seem to prize them very highly.

Securing Good Medical Staff in Dispensary

Someone then brought up the question as to how to secure a good medical staff for the out-patient department. Mr. Ransom said that some join the out-patient staff because they hope to get on the hospital staff through this channel. At the Michael Reese Hospital, Chicago, the board of trustees recently passed a resolution that when a vacancy occurred in the hospital staff, first consideration was given to those doing good work in the dispensary. We are now getting away from the idea that a man may be good enough to work in the dispensary, but not in the hospital.

Dr. Frank Billings, president of the American Conference on Hospital Service, said that the hospital and dispensary should most certainly be considered one field of endeavor in the welfare world. Their work should be more correlated. In some cases dispensaries and hospitals have been under different boards in matters of finance, administration, etc. They were sometimes two separate institutions. The desire on the part of medical men to be in hospitals rather than in dispensaries, Dr. Billings feels, is due to a lack of knowledge of the service in the dispensaries. The dispensary should be a diagnostic clinic, the place to find out if a patient needs hospital care. Dr. Billings said that 20 per cent of all patients coming to the dispensary would need to go into the hospital.

Open Hospital Facilities to Dispensary

One method of attracting better men to the dispensaries, Dr. Billings believes, would be the opening of the hospital facilities to the dispensary. He said that his own dispensary service had given him greater satisfaction than a large medical service in the hospital, because of the rarer and better material that he found there. He spent more time in the dispensary because he found there the beginnings of disease, while in the hospital he found the end results. In many of the countries abroad the personnel of the dispensaries is as good as, if not better than, that in the hospitals. Financially it would be better to have the dispensary and the hospital organized as one institution, because then money could be raised for both at the same time. Dr. Billings went on to say that he knew of no hospital in Chicago which would close its doors to a patient able to pay ward fees, but as soon as the dispensary takes a patient who can pay a fee someone objects. The dispensary ought not to receive as indigents those who could pay the doctor. If the dispensary had hospital facilities it could diagnose patients sent in by doctors, then if it treated the doctors fairly it would send their patients back to them. This would give better service to the community and lessen the trouble between dispensaries and doctors.

Should Only Accept Patients Through Dispensary

Hospitals, said Dr. Billings, would amplify their service to the community if they would accept as a general rule only patients going through their dispensary. He felt that the dispensary fee should not be less than the amount that would be charged in the community for those who can pay. The institution must not be a competitor of the physician of the community.

Mr. Ransom said that in a dispensary with which he was formerly connected a $5.00 fee was the limit which could be charged, but it was heartbreaking to turn away patients just over the financial line, leaving them to get inferior treatment from doctors outside. This difficulty is being met in some measure by pay clinics. Dr. Alec N. Thompson, New York City, asked the question, "What basis could be used for the compensation of physicians in the dispensary?" For example, a $10,000 man should be paid by the dispensary $5.00 an hour, but the patient would then have to pay more than he would outside. Can these two factors be adjusted satisfactorily? It was the opinion of most of those present that this question had not been solved. Dr. Billings said that it was the tradition of the medical profession that the knowledge gained and the service rendered in dispensary work was sufficient compensation. He realized that conditions had changed today, but few dispensaries have sufficient budget to pay for whole-time service. Some can pay for part-time, perhaps one man in each department of service.

MR. R. M. BRADLEY, whose paper on "An Unexploited Source of Money for Hospitals and Other Organized Work for the Sick" was read by title.

The Dispensary as a Diagnostic Clinic

A possible solution, went on Dr. Billings, is the dispensary as a diagnostic clinic, receiving all patients, and being one with a hospital having sufficient money to pay for medical service. This is the policy of the Mayo Clinic, where the patient is diagnosed, then sent back to his physician with suggestions for treatment. Mr. Davis felt that such a clinic was entirely practical. Dr. Billings summed up his idea of the dispensary as a diagnostic clinic by saying that it was good for the patient, because he got better treatment at a moderate fee; good for the doctor, because he could carry on the treatment afterwards; good for the hospital, because the dispensary becomes a feeder for its beds; and good for the community because of the fuller service rendered to its people.

WOULD YOU BRING YOUR ENTIRE BOARD OF TRUSTEES TO A CONVENTION?

You may be a firm believer in the conventions of the American Hospital Association, but would you transport your entire board of trustees half way across the continent to attend it? This act of faith was done by Mr. H. F. McGregor, who is president of the board of trustees of a new hospital which is being planned for Houston, Texas. He realized that the latest ideas in equipment would be exhibited both in the commercial and non-commercial exhibits, and that the sessions would be full of constructive ideas which would be of inestimable value in the future work of establishing and running their proposed hospital.

DR. FRANKLIN H. MARTIN REVIEWS STANDARDIZATION WORK OF A. C. OF S.

DR. BILLINGS presided at the Joint Session of the American Conference on Hospital Service and the American Hospital Association, on Thursday at 10 a. m., and introduced as the first speaker Dr. Franklin H. Martin, secretary general of the American College of Surgeons, Chicago, who talked on the work of the College. The American College of Surgeons, said Dr. Martin, if it has made an impression on the hospitals of the country, has done so because it has attempted to do something worth while. The College, which has been in existence since 1916, consists of 5,000 surgeons. At its beginning it found its duties to be, first, the betterment of surgery, and second, the elimination of unnecessary surgery. It found that the first thing to be done was to have a way of standardizing its own body of surgeons. Naturally it came in contact with the environment in which surgery was done.

It was also necessary to have some standard of admission to the College, so it was decided that each surgeon should file full records of fifty cases done by himself and fifty more in abstract. The records came in in all kinds of shape—some on newspapers, some on writing paper, but they were passed upon as they were. It soon became evident, however, that there should be some uniform system of records. The College had at that time no idea of going into the hospital field, or of trying to standardize hospitals, but a committee of specialists was formed and a form record was made up, which could be used if desired. Hospitals soon began to ask for copies, then asked for the requirements of the College. They were told that there were none, except that the doctor should do his work properly.

Hospitals Ask for Some Standard

At the beginning of the war, hospitals asked for some little standard that they could follow, and in consequence, a committee meeting was held in Washington, in connection with the Army, Navy, and Public Health Service. Six months later the College decided to analyze some hospitals in which surgery was being done, and it was not until six months after this that the minimum standard was drawn up. The minimum standard consists of three things which surely could not be questioned by anyone: first, records in the hospital; second, an organized staff of honest men; and third, a laboratory. Hospitals began asking the College to visit them to see if they were meeting the standard. Reluctantly the College consented, but first it went to the American Medical Association and asked if this body would not attempt to do it. The Association said that it would decide what hospitals would be acceptable to interns, but it would not do the other. It stated that it had no objection to the American College of Surgeons doing it, and therefore the College accepted the program.

Why Was the College Asked to Do This?

Why was the College asked to do this, and why was it interested in doing it? It was asked to do it because it was in a position to finance it. It was interested in doing it because it wished to standardize the environment of its surgeons. The College had no authority except the authority of the ideal. The way it has been accepted shows that it was desired by hospitals. Surgeons wanted it, medical men also wanted it, patients more than all required it, and superintendents were getting tired of running boarding houses in which all kinds of patients were dumped by all kinds of doctors.

The difficulties of the survey were not as great as might have been expected. The surveyors are young men, graduates of Class A schools, having had internship in a fine hospital connected with a school. In its instructions to them the College impresses upon them the fact that their personality and appearance and the general impression made by them, is made for the American College of Surgeons. Their mission is business. Their motive is to give facts, not to make comparisons, and then present other facts in return. Their success, it has been impressed upon them, will depend upon their personality and sincerity.

Survey Meets with Remarkable Success

The survey was begun three years ago, with 100-bed hospitals, 697 in all, in the United States and Canada. In 1918-19 only eighty-nine of this number met the minimum standard. The next year 198 met it, and last year 407 met it, or agreed to meet it. This year it is hoped that there may be nearly 550. This year and last a large number of fifty-bed hospitals were visited; next year they will be included in the survey.

Last year, criticisms began to be made of the College, and although they were few, they made more of a stir than the silence of approval. These criticisms are now being changed to receptivity. When the surveyors go to a city they are besieged by hospitals asking them to visit their institutions. The College is spending a great deal of money on this proposition. In the year August 1, 1920, to August 1, 1921, $64,000 has been spent on standardizing alone, not counting the overhead. Having started this program, the only thing for the College to do is to finish it up. The survey will be continued this year and next, and after that it will be necessary to remain interested in hospitals, because of the initial idea with which it started—to standardize surgery.

Dr. Martin Advocates Raising Membership Fee

Dr. Martin quoted Dr. Billings as saying that he felt the inevitableness of the government taking over medicine. Army men were treated by specialists, and under team-work. Now they are saying, "Why can't we have the same thing when we are out of service?" Medicine is becoming so scientific that it requires a longer period to get a diploma, which means that we are getting fewer doctors. Therefore we have got to stop the retail practice of medicine and adopt wholesale methods. This is what is being done in hospitals; they furnish facilities, and a group of men, though not necessarily banded together. The College believes that scientific medicine should direct all of these things and that then the quack will have to go.

Dr. Martin said he realized what an enormous organization the American Hospital Association was, and what a power for propagating this doctrine. Yet the Association has not the financial backing it needs, and considering what it means to hospitals to have such an organization behind them, he advised the raising of the dues for institutional members to $25, $50, and $100, according to the size of the hospital, and personal membership to $10. This he believed would solve the problem of financing.

Dr. Billings said, in regard to the relation of govern-

ment to medicine, that there was an alarm on the part of the medical profession for fear there would be a paternalism established. He believes that the fear is unfounded. He also thinks that all centralization of welfare work will result in disaster. The small hospital, if it gives good service to the community and is adequately administered, will be better than the public hospital. It is a well known axiom that "Welfare work that is worth while must be paid for, and must be done by the people benefited."

Dr. Nuzum Speaks on Medical Efficiency

The paper read by Dr. Franklin R. Nuzum, Santa Barbara, Cal., dealt with "A Method for Increasing Medical Efficiency within the Hospital." "There is no agency within the hospital," said Dr. Nuzum, "which is working for the uplift of medicine, although there are many on the outside. Therefore, if hospitals are to keep pace with the demand for better medicine they must assume responsibility for the patients' progress, and the three functions attributed to them: (1) the care of the sick; (2) the education of future personnel; (3) research and medical science. For this work the full time service of a medical man should be procured, who might be called a 'medical director.'"

His first duty would be the organization of laboratories. He would bring about the proper staff organization with the various sub-groups. He would keep in touch with the especially difficult cases and offer suggestions if possible, or advise further consultation if indicated. The cooperation and spirit of helpfulness which it is possible to develop, create in the institution a postgraduate school. Such a staff would eliminate the competitive element of present day medicine and put in its place the newer ideals of specialization, team-work, and intensive study of individual patients.

Another opportunity of the director would be to further the taking up of new procedures by the profession. He could also give attention to the advancement of research and medical science.

One difficulty with this plan is to secure the right person. It would take a well trained man, of broad vision, sympathy, and tact. The other difficulty is financial. Perhaps fees from the laboratory after the staff had been made to realize the importance of routine tests, would cover the expense. Or perhaps a friend of the institution interested in the plan would personally meet the added cost.

The patient cannot get the treatment which he expects in a hospital under a nursing régime. Hospitals must become medical institutions with the same elements of team-play and cooperation among the various specialists and men on their staffs that are found in group practice and health centers outside.

Twenty-two Million Need Medical Treatment

In a discussion on Dr. Nuzum's paper, Dr. Billings said that the fact that hospital care was necessary was shown by the figures which set the number of people in the country needing medical treatment at 20 per cent of the population, or 22,000,000. Approximately 80 per cent of the people who are ill have diagnoses made, and need the facilities which hospitals offer. Eighty per cent of these will not need hospital care, leaving 4,400,000 who will. Therefore, hospitals with diagnostic facilities must be placed in communities for these patients. Laboratories must be made available for everyday practical work, which merely means carrying out the minimum standard.

Dr. Dodson of Chicago said that the sooner the hospital becomes a practical teaching center the sooner will it improve its service, and the character of its staff. We have in this country three types of practitioner—the graduate, working in large centers, and the specialist, these two types being taken care of in the well organized schools. There remains the third group of the large number of medical practitioners who feel the need of brushing up courses. The solution of polyclinic work is in the organization of 300 to 400 hospitals of 100 or more beds as study centers. They should give the practitioner the opportunity to study physiology, pathology, etc., the fundamental things rather than surgery, which the medical practitioner does not need.

Daily Teaching Clinics Successful

One superintendent stated that at his hospital in Chicago they held teaching clinics every day, gathering together on an average of about twenty-two men a day. The clinics are in charge of the director, and doctors bring in their cases for discussion. This plan is leading to splendid results. It develops the intern and nursing staffs, as well as the medical staff of the hospital, and outside men are beginning to come in.

Another speaker said he thought the College would help hospitals more if it would urge medical men to raise their standards, as the greatest difficulty of the superintendent was getting them to keep medical records. Dr. Martin said in reply that the College had found medical men more willing to cooperate than some of the older surgeons. Although he does not understand the reason, superintendents and medical men have given the College better support than surgeons.

CLINIC "TRAFFIC" FILM SHOWN

During the Convention there were several showings of a one reel motion picture prepared by the American Social Hygiene Association, which demostrated the "traffic lanes" through which the patients flow in a well-managed venereal disease clinic. Animated diagrams illustrated the problems facing the person responsible for the smooth running of the clinic. The principles outlined are applicable to any clinic. At each showing the film was introduced by Dr. Thompson, director of the department of medical activities of the American Social Hygiene Association. An informal discussion followed each showing.

TWO STATES ORGANIZE ASSOCIATIONS

At the West Baden conference a number of the Pennsylvania hospital superintendents held a meeting at which Mr. Daniel D. Test, superintendent, Pennsylvania Hospital, Philadelphia, was chosen as chairman of a committee of three to arrange the time and program of a meeting to be held at Harrisburg, Pa. It will occur sometime in November, and for the purpose of organizing the Pennsylvania Hospital Association as a geographical section of the American Hospital Association. Dr. Zulof was appointed chairman of the committee to draw up a constitution and by-laws. A Missouri State Hospital Association is also being formed according to information received from R. E. Castelaw.

SUPERINTENDENT OF ROOSEVELT HOSPITAL DIES

Charles B. Grimshaw, since 1907 superintendent of Roosevelt Hospital, New York City, and previously assistant superintendent for fourteen years, died recently. He had been confined to his bed for several weeks with acute leukemia, from which he had suffered for several years. Mr. Grimshaw was fifty-eight years old.

IMPORTANT REPORTS READ AT SESSION OF THE AMERICAN CONFERENCE ON HOSPITAL SERVICE

THE open session of the American Conference on Hospital Service, on Thursday afternoon, at which the president, Dr. Frank Billings, professor of medicine, University of Chicago, presided, was held in the covered track which circles the baseball field.

Miss Mary C. Wheeler, superintendent of nurses of the Illinois Training School, Chicago, submitted a brief report supplementing the report which she made at Montreal, as chairman of the committee charged with making a comprehensive survey of the nursing situation.

At the meeting of the American Conference on Hospital Service, held in Montreal in October, 1920, a report was read which had been compiled by your Nursing Committee.

Additions, Miss Wheeler stated, had been made to the charts, begun last year, which shows the dates of organizations of the Schools of Nursing and the number of nurses graduated from these schools year by year. This data is arranged by states and is from those schools only which were upon the accredited list of schools January 1, 1920.

For the reason that a number of schools have failed to make any report and that many times the answers were inadequate, the charts can give us but a few general ideas. When completed, they will be of historical value.

The dates of organization of the schools are important, as the chart thus shows the rapid increase of schools of nursing through 1910 and then the decrease. Blocking the chart off in ten-year periods, it shows that there were:

14 schools organized between 1872 and 1880
83 schools organized between 1881 and 1890
306 schools organized between 1891 and 1900
446 schools organized between 1901 and 1910
289 schools organized between 1911 and 1920

The question of the education of boards of managers, architects, medical men, nurses and lay executives and teachers for this new, untried, and rapidly developed field might well be considered when studying the reasons why the nurses' education needs attention at the present time.

Miss Wheeler gave the following figures as the output from the schools, year by year, for the last five years: Nurses graduated in 1916, 9,573; 1917, 9,962; 1918, 10,836; 1919, 10,898; 1920, 11,972. A report for 1921 has not been made possible, but judging from such data as has been sent in, there is a sharp decline in numbers.

Miss Donelda R. Hamlin then read her report as director of the Hospital Library and Service Bureau. (This report appears in full on page 332.

Although this was not the annual meeting, Dr. H. E. Mock submitted an informal report as treasurer, showing balances as of August 31, 1920, as follows: General fund, $244.50; nursing fund, $127.38; Hospital Library and Service Bureau fund, $4,953.78; total, $5,325.66.

The report of the trustees was read by Dr. A. R. Warner, executive secretary.

It stated that the trustees, since the last report, had held one meeting on March 9, 1921, at which certain important resolutions were adopted. First, that only such national organizations should be recommended for membership as are qualifed by organization and field of activity, and which manifest sufficient interest in the work of the Conference. Second, that a special committee be appointed by the president to formulate the procedure by which the Conference shall determine upon, adopt, and advocate specific policies, standards, or approved methods in hospital service, to report to the trustees, this procedure giving protection to the constituent members of the Conference against hasty or ill-considered action. The Library Committee presented a draft of by-laws for the Library which were approved and adopted.

Dr. M. T. MacEachern expressed amazement at the remarkable amount of work which has thus far been accomplished by the Hospital Library and Service Bureau, and urged hospitals not only to use its services freely, but to help the library by sending it good articles, hospital plans and annual reports.

Dr. Frank Billings urged every constitutional member of the Conference to contribute to its support and announced that the American Medical Association had voted to repeat its contribution of $1,000 for the coming year.

Dr. Dodson, dean of Rush Medical School, Chicago, Ill., urged delegates to take back from the Conference the reports of the meeting and to devote a session or a part of a session of their annual meetings to a discussion of the work of the Conference and of the Hospital Library and Service Bureau. Dr. Billings announced that the Conference had been invited to become a member of the National Health Council, but that before accepting the invitation a delegation would go to the National Health Council to learn more of its purposes. The session closed with a discussion of what subjects might be considered at the annual meeting of the Conference in March. One of the questions suggested was the present shortage of interns.

WILL HOSPITALS ADOPT THE FORTY-FOUR HOUR A WEEK PLAN?

In a recent number of the *Royal Prince Albert Gazette* in Australia appears a discussion of whether the new movement for forty-four hours of work per week will be applied to hospital labor as well as to that of other trades. The Court of Industrial Arbitration has already reduced the hours for carpenters, electricians, plumbers, and fitters, and in the future these workmen will work forty-four hours a week, during five and one-half days for the same pay that they have been receiving for forty-eight hours of work. Application has been made on behalf of some of the staffs of hospitals for similar provision. It is rumored that the Hospital Employees' Union has applied to the Court of Industrial Arbitration of New South Wales for an enquiry into the hours of labor of employees engaged in hospitals, with a view to their reduction to forty-four as in the other trades. Such an important change as this would certainly fall heavily on the hospital, necessitating a large increase in personnel. It remains to be seen what action will be taken by the Court if the question comes up for its consideration.

"The dispensary method of control, with its tuberculosis specialists, its visiting nurses, social service departments, educational work, and general preventive measures, including the examination and protection of contacts, especially children in the homes, is still the most economical and only method which reaches tuberculosis where it begins, as well as the one most strategically placed at the crossroads of patients going to or returning from institutions or remaining at home.—*1920 Year Book, Association of Tuberculosis Clinics of New York.*

IMPRESSIONS OF THE CONVENTION AND UNCONVENTIONAL INTERVIEWS

By OTHO F. BALL, M.D., President, The Modern Hospital Publishing Company, Chicago

TO BEGIN with, the Convention this year was not a "convention" in the ordinary sense of the term—rather it was a big house party with the guests drawn from all parts of the country. Mr. Rexford, president of the West Baden Springs Hotel Company, in his capacity of host, created for everyone an atmosphere different from that of any previous meeting of the Association.

When West Baden was named as the place where the hospital people were to come together, it seemed a happy selection because of its proximity to the South and its easy accessibility from all points. Further, the advantages of the representative hospital people of the country being under the same roof for a week seemed likely to develop still further that fine feeling of mutual helpfulness which is so characteristic of the hospital field. It is this spirit which has made hospital administration a profession in the truest sense, and never before was it exhibited to so great an extent as at this year's Conference.

Reference is made above to West Baden's proximity to the South. The quiet restfulness of the place, the wooded hills, the softness of the air, and the well ordered service given by the old fashioned colored servants belong to the southland. Nor was the appreciation one-sided. A fine old darky waiter who has been attached to the hotel for several decades confided to me while serving breakfast the day of my departure: "Ise bin listenin' to these white folks talk as they eats and I calclate hosiful people always thinks of other folks and never bout themselves."

The Conference was a success—easily it was the best meeting I have attended, and it has been my privilege to be at all of them since the one in Boston in 1913. The measure of success was not in the set program—excellent as were the papers and discussions—but in the house party informality which encouraged all to think aloud and to exchange ideas on a basis of intimacy which is seldom established when conventions are held in the metropolitan centers.

When talking of their work, and of course most of the conversation was shop talk, every superintendent seemed to be thinking of the person for whom the hospital exists—the patient. I wish that John Bowman and Father Moulinier could have been present, both in the set meetings and in the informal discussions, because they would have had so much evidence of the splendid results from the crusade started by them several years ago.

After all, the greatest value of these annual meetings of hospital people comes from the informal discussions, or what might be called the impromptu round tables, of which there were many held between sessions. An important result of the West Baden meeting is that each superintendent became acquainted with more of his kind than at any previous conference, and on every side were heard lively discussions covering the whole range of hospital, dispensary, and social problems.

By a Staff Photographer.

The headquarters of the reception committee of the Indiana Hospital Association.

The most distinguished figure at the Convention, from the standpoint of personal attainment in medicine and

public service in many fields, was Dr. Frank Billings, president of the American Conference on Hospital Service. Dr. Billings sees a big work ahead for the Conference, and a constantly broadening field of usefulness for the American Hospital Association. One of Dr. Billings' outstanding characteristics is his keen sense of humor, even when the joke is on himself, and in this connection he told over the luncheon table the story of one of his experiences when on the witness stand may years ago. The cross-examining attorney, after putting the usual questions of age, residence, etc., ad infinitum, asked the doctor if he was the physician of Mr. George Pullman. "Yes," said Dr. Billings. "Where is Mr. Pullman now?" was the next question. "He is dead," replied the doctor. "Were you not the physician of Mr. Marshall Field?" "Yes," was again the answer. "Where is Mr. Field now?" "He is dead." "I believe Mr. Philip D. Armour was one of your patients?" "He was." "And where is Mr. Armour now?" "He is dead." "That is sufficient," said the attorney.

It was very pleasing to be assured by Mr. Daniel D. Test of Philadelphia that the historical old colonial building of the Pennsylvania Hospital is to be preserved, although plans for expansion call for extensive new construction on the present site, to meet the constantly growing needs for greater bed capacity. Fortunately the Pennsylvania Hospital property will permit the new construction, although doubtless it will tax the ingenuity of Mr. Test, the hospital consultant, and the architects to bring about this very commendable preservation. Those of us who attended the Philadelphia meeting of the Association, recall with a great deal of interest the history of the Pennsylvania Hospital, as given to us at that time. This is the oldest hospital building in the United States, the east wing having been erected twenty years before the Revolutionary War. In this connection it is very interesting to know that Mr. Test is now starting on his thirty-first year with the Pennsylvania Hospital, and doubtless the splendid spirit of that institution is due, not alone to the personality of this exceptional man, but to his very long period of service. And here is a lesson for other superintendents and boards of trustees—if the right individual and the right institution are coupled up, then a lifetime of service will build that kind of a spirit within the hospital, which can seldom otherwise be obtained.

Mr. Bacon the New President

Mr. Asa S. Bacon of the Presbyterian Hospital of Chicago, for so many years treasurer of the Association, was the center of many informal conference groups and in his quiet unassuming way was rendering that high degree of service to others for which he has always been noted. The large volume of experience and the unusual qualifications of the man, make his advice of extreme importance, not only to the young workers in the field, but also to the older ones as well. Over Mr. Bacon's earnest protest the nominating committee insisted upon his accepting the presidency of the Association, displaying a wisdom in selection, not alone in choosing a man of such broad experience, but one who has a place in the hearts of the entire membership of the Association.

Dr. Martin Reviews Work of College

Dr. Franklin Martin, secretary general of the American College of Surgeons, is always a distinguished figure in any gathering, and his presence at West Baden, and the message which he brought to the Convention regarding the hospital activities of the College, commanded an unusual degree of attention and enthusiasm. Like Dr. Billings, Dr. Martin is rounding out a distinguished professional career by unselfishly devoting all of his energy to the advancement of medical and allied service.

Dr. A. C. Bachmeyer, general superintendent of the Cincinnati General Hospital, gave some interesting information regarding the effect of prohibition on the work of his hospital, which will not be detailed here, although this incident will be related. Two orderlies, Pat and Mike, long attached to the institution, had been imbibing a little bit too freely during the evening, and on returning to the institution created a disturbance which of necessity must be reported to the administrative office. A part of the detailed conversation is as follows: Mike—"I feel so foine that if I feel as foine as this in the mornin' I'll buy this place." Pat—"And if I feel as foine in the mornin' as I do now I'll sell it to you!"

Father Griffin's Malady Progressing

It is hoped that the editorial entitled "The Epidemiology of Golf," published in the September number of THE MODERN HOSPITAL is still in the minds of the readers. Now we will let you into a secret. Not the author of the editorial but its real inspiration was Father M. F. Griffin, director of Catholic Charities, Youngstown, Ohio; that is, Father Griffin is the infected patient on whom most of the observations were made. It is gratifying to report that the patient in this instance is making good progress, and with each of his shots observed on the West Baden golf course he approached a little nearer to the green—a little, not much!

Father Griffin has brought to the hospital field a vision of service that is inspiring. His broad-minded analysis and discussion of all phases of the work is productive of much good. He is a wise counsellor, an indefatigable worker, and a sincere friend, with an all-inclusive interest in social problems.

Hospital Reorganized on Efficient Basis

Mr. C. J. Cummings, superintendent of the Tacoma General Hospital, Washington, was present from the Pacific Coast. Mr. Cummings came to the Convention full of enthusiasm, having recently completed the reorganization of the hospital on a most efficient basis. A recent addition to the staff is a full-time highly experienced pathologist. Mr. Cummings has been in charge of this hospital for only three years, and when he assumed the superintendency there was a debt of $110,000 due for new construction which was completed shortly before he went to Tacoma. The money to pay off this debt was raised through a loan from one of the insurance companies, secured by a mortgage on the property, and further secured by policies of $5,000 each on twenty-two members of the visiting staff and board of trustees. Through careful attention to collections from patients who could afford to pay, $20,000 has been paid on the mortgage, as well as a reduction of current indebtedness by an equal amount. Patients are asked to pay weekly, in advance, and to make provision for further payment if their stay is extended. No indigent person, however, is refused accommodation, and the institution is doing a considerable volume of free work.

Miss Loveridge, of the Good Samaritan Hospital, Portland, is one of the young-old veterans in hospital administration on the Pacific Coast, having been in charge of this institution for more than thirty-five years. The hospital has launched out on an extensive building program, and is completing a separate maternity wing, and an additional wing to the main hospital for general cases. This will increase its accommodations to 350 beds.

Dr. M. T. MacEachern of the Vancouver General Hos-

pital, stated that owing to the rapid growth of his training school, which has now over three hundred nurses in training, a reorganization of the instruction and applied nursing work is being considered, which will probably link up more closely the department of nursing in the hospital with the department of nursing in the university. Dr. MacEachern, like the other superintendents in Canada, does not have the difficulties of some of the hospitals in the States in the matter of procuring a full quota of superior material for nurses' training. The requirements call for a high standard of health, a preliminary physical examination being made before entrance and on admission by the hospital authorities, and an academic education of at least three years high school. This training school is now in the happy position of being able to secure sufficient young women for matriculation from graduates of the university. At present about one-third of the class are ex-school teachers. Dr. MacEachern properly places great importance on the physical fitness of the nurse applicant, and it would be in the interests of hospital efficiency for other superintendents to consider this important matter more carefully. The Vancouver General Hospital at this time has 1,200 beds, and is the largest general hospital in the Dominion. It has a nurses' training school of 360, and last year cared for 15,000 inpatients.

Dr. MacEachern Active in Canada

In addition to his efficient administration of this big hospital Dr. MacEachern has found time to help practically all of the other hospitals in Western Canada, and at all times he is not only ready to receive the superintendents in his own institution, but he makes many trips to the remote towns of the Western provinces for the good of the cause. Sixteen of the nurses at the Vancouver General Hospital are now taking the five years' course leading to the nursing degree. This nursing degree comprises five years' study after the young woman has matriculated into the university. The faculty of nursing education in the university is under the applied sciences; the first degrees will be presented at Convocation in 1923. The degree will probably be the Bachelor of Science in Nursing. The first two years of the course are academic and are spent at the university. Between the first and second year in the university the probation period is taken in the hospital. The third and fourth years take in the regular nursing course, and the fifth year is spent between the hospital and the university, with privileges of election of one of three courses: public health, teachers' training course, and hospital administration. The public health nursing course in the university today comprises the university year, and through the Victorian Order of Nurses of Canada, scholarships of $400 each are given to all nurses wishing to take the course, and fifteen or twenty of these nurses are now entering the University of British Columbia with which the Vancouver General Hospital is affiliated.

Personal Letters to Physicians Bring Nurses

Dr. W. L. Babcock, superintendent of the Grace Hospital, Detroit, was very much pleased with the result of his effort to increase the number of applicants for the training school of his hospital. Personal letters were sent to some thousands of physicians in Michigan, asking them to urge high school graduates to consider seriously the taking up of nursing as a profession. The results were highly satisfactory, and instead of a scarcity of nurses Grace Hospital now has a waiting list of candidates. This suggests the importance of closer cooperation between hospitals, and especially metropolitan institutions, with the medical profession throughout the country, because, very properly, the family physician is consulted by his clientele on matters of the education and other details in the careers of their children.

One of the familiar figures missed at the West Baden meeting, and an individual who is at all times recognized as a leader of thought, was Dr. S. S. Goldwater, who is one of the large party of distinguished American scientists and health workers accompanying the official party of the Rockefeller Foundation to China, for the dedication of the Peking Union Medical School and Hospital. This important contribution of the Foundation to China is also responsible for the Association's being denied the presence this year of Dr. George Vincent and Mr. Edwin R. Embree, the president and the secretary of the Foundation, although it was fortunate in having Miss Norma Stoughton, the assistant secretary, in attendance both at the Hospital Association and the American Conference of Hospital Service.

Work of Hospital Discussed at Luncheons

Dr. George Stephens, general superintendent, Winnipeg General Hospital, went to this institution following his service in the war. He has rapidly built up a medical education center in the hospital, inasmuch as it is closely associated with Manitoba Medical College, one of the leading institutions of Canada. Through Dr. Stephens' efficient administration, the institution is the last word in efficiency, cooperation, and *esprit de corps* amongst the medical men of Winnipeg. One of the features which has brought this about is the luncheons and dinners which he has at regular intervals at the hospital, in which the whole medical and administrative work of the institution is reviewed. Dr. Stephens is president of the Manitoba Hospital Association, and is doing much to solve hospital problems, especially throughout rural communities of the Province.

Rev. A. G. Lohman of the Deaconess Hospital, Cincinnati, who commands not only the respect, but also the affection, of all who know him, worked in his usual arduous way at the Convention this year for the development of the state sections of the national organization, feeling that it is by the development of these state sections that the most good can come out of the national meetings. Mr. Lohman is very active in the membership work of the Ohio section of the American Hospital Association.

Dr. Haywood Amalgamating Two Hospitals

Dr. A. K. Haywood, superintendent of the Montreal General Hospital, assumed charge of this hospital after his return from overseas. The Montreal General Hospital today shows some of the leading features of hospital administration that can be seen anywhere, especially in reference to the dispensary and the dental clinic, consisting of some sixty chairs, and particularly in relation to scientific investigation and research. One of the big problems on Dr. Haywood's hands at present is the amalgamation of the Montreal General Hospital and the Western Hospital, which has received the approval of the trustees, and is now rapidly proceeding with plans of amalgamation and organization. When the money is secured and the plan is complete, efficient and elaborate arrangements will be made for all types of cases.

Mr. T. T. Murray, superintendent of the Saskatoon General Hospital, comes from a Province in which hospitalization is being developed rapidly along definite lines, fostered by the Provincial Government, with financial aid given on a basis of land taxation at so much per quarter section, thus giving the hospital a definite budget, which is

apportioned on the basis of the number of hospital days without reference to whether service is rendered to free or pay patients. A further advantage is that a definite arrangement has been made for every hospital to establish the necessary scientific facilities for proper diagnosis and efficient treatment. This Province of Saskatchewan, which is so little known to many of the readers of THE MODERN HOSPITAL in the United States, bids fair to set some standards to which all of us must look for guidance. Mr. Murray states that the Saskatchewan Hospital Association, the Western Canada Catholic Association, the Saskatchewan Nurses' Association, the Western Canada Hospital Association, will all meet in Regina the first week in November. The Western Canada Hospital Association, of which Dr. R. R. Seymour of Regina, commissioner of public health for the Province, is president, combines the four western provinces—Manitoba, Saskatchewan, Alberta, and British Columbia. This Association has been organized for the purpose of bringing about the betterment of hospitalization and the increase of efficiency.

Hospital Ready March 1, Says Dr. Woodbury

Dr. Wiley E. Woodbury of the Fifth Avenue Hospital, New York City, who also is associated with Dr. S. S. Goldwater in hospital consultation work, expects the new Fifth Avenue Hospital buildings to be ready for occupancy about March 1. The hospital is rather different from most present day hospitals, in that individual rooms, 340 in number, are provided for patients, and that by reason of its X shaped arrangement each room is an outside one. The building has two basements, and is nine stories in height, with a roof garden, and will cost, when completed and fully equipped, approximately $3,000,000. This hospital is the result of the consolidation of the Hahnemann Hospital and the Laura Franklin Free Hospital for Children. The entire second floor of the Fifth Avenue Hospital is given over to the care of children, and there is a bed capacity of ninety on that floor. A very interesting feature of this children's floor is that practically all partitions are of glass, thus giving the nurses on duty a free view of every cubicle. The roof garden has a solarium in the center for winter time use, and has protected shelters, thus giving three degrees of roof service—the closed solarium for winter, the top protection, and another part of the roof entirely open. An interesting feature is that suites of offices are provided for the chief of every department. These offices consist of a private ante-room, an office, and a treatment room, and the chief of the department will be required to spend his working day in the hospital, and to receive within the hospital building all of his private patients. A detailed story of the Fifth Avenue Hospital will be presented in due time in the columns of this magazine.

Enthusiastic Over New Out-Patient Building

H. E. Webster, of the Royal Victoria Hospital, Montreal, who is known as a delightful host to those of us who sojourned as patients in his institution incident to last year's meeting of the Association, is enthusiastic about the new out-patient building of the Royal Victoria, which will be in service in early October, in time for the McGill University Centenary Reunion. A special feature of this building is an attached room or amphitheater accommodating twenty students in connection with each of the five departments of medicine. This will mean that each patient will have contact only with those twenty students who are attached to the special division in which his case belongs. There will also be a general amphitheater in the building which will seat one hundred students. Webster, as well as all the other Canadian superintendents, expressed great enthusiasm regarding the splendid progress which Canada is making in hospital service and the constantly improving standards practiced throughout the Dominion.

Pittston Hospital Has Flexible Organization

The superintendent of the Pittston (Pa.) Hospital, Miss Esther J. Tinsley, has an interesting problem in hospital service because the institution is located in the anthracite coal region and is the only hospital in a locality of 60,000 population. In Pittston alone there are 10,000 men employed in the coal mines and it is a splendid tribute to the safety work of these mines that the hospital seldom has more than two or three accident cases from them at one time. Necessarily this hospital must be organized for quick expansion of its facilities and it was put to the test a few months ago when a railway accident in the vicinity seriously injured forty people, among them being seven fractured skull cases and numerous compound fractures of the long bones. Miss Tinsley was a passenger on the wrecked trolley car and was one of the first to be removed from the debris. Without giving thought to her own injuries she reached her hospital by telephone and made arrangements whereby service was immediately available for all of those forty patients and proper facilities were provided for taking care of the bodies of nineteen dead. This speaks well for the service of this small hospital—that with poor equipment it cared for all of those patients, discharging all cured without calling on outside aid, and it is pleasing that Miss Tinsley's work is so appreciated within the community that there are assurances of a more modern hospital with greatly increased facilities within the next year—a campaign for $300,000 now being under way.

Dr. K. H. Van Norman Represents Johns Hopkins

Dr. Winford H. Smith of Johns Hopkins was missed, but the institution was ably represented by Dr. K. H. Van Norman, who stated that the plans for the new pathological building are completed and that work will be started this autumn if conditions are favorable. After the construction of the pathological building the next in line will be the women's clinic, which it is hoped will be started next spring. The third of the proposed new buildings will be that for dispensary and surgical work. By the way, Dr. A. J. Lomas, who left Johns Hopkins about the middle of August to assume superintendency at the University Hospital of Iowa State, has been succeeded on the Hopkins staff by Dr. C. H. Goddard of Baltimore.

Dr. L. B. Baldwin, the retiring president of the Association, was properly congratulated by all on his efficient administration and on the success of the West Baden meeting. In addition to so competently leading the Association for the past year, Dr. Baldwin has not only been the administrative officer of the University Hospital, Minneapolis, but has built, equipped and opened the 216-bed Miller Hospital at Saint Paul and, incidentally, he is also director of the Nicollet Clinic of Minneapolis. This clinic is an organization of medical men effected for group practice—the group consisting of eighteen of the prominent physicians and surgeons of Minneapolis, all of whom are members of the faculty of the medical school of the University of Minnesota. The group covers all medical fields with the exception of pediatrics, and it properly includes dentistry.

Dr. Ancker Sends Greetings

Many were the expressions of regret because of the absence of that veteran administrator, Dr. A. B. Ancker, of Saint Paul, whose service to the sick in hospitals began

many years before the organization of the American Hospital Association was contemplated. Through Doctor Baldwin, president of the Association, Dr. Ancker sent greetings to his many friends and also the assurance of his attendance at the next meeting.

Dr. B. A. Wilkes of the Missouri Baptist Sanatorium, St. Louis, is running to capacity from six to eight operating rooms daily, averaging 250 major operations each month. An interesting development in the Sanatorium during the past year is the goiter clinic with Dr. Willard Bartlett in charge, to which patients are coming from all parts of the Middle West and South. During the past few years the Sanatorium under Dr. Wilkes has been expanded to 300 bed capacity.

Dr. Walter E. List of the Minneapolis General Hospital, shows no effect in his appearance of the strenuous work done by him in almost completely revolutionizing the institution as relates both to the physical plant and the internal organization. Dr. List has done a big piece of work in a hospital which has long been regarded as one presenting many difficult problems in administration.

Less Needless Noise than Ever at Mount Sinai

From Frank E. Chapman, Mount Sinai Hospital, Cleveland, I was able to secure some additional information regarding the suppression of noise in his institution. Some months ago Chapman organized a Society for the Prevention of Needless Noise—the work of which is carried on by the personnel of the hospital. The Society was organized with the thought that if it could become popular and if the effort for noise suppression be a constantly continuous one results would be very beneficial to the patients. Monitors were appointed from all classes of the hospital personnel. They reported daily by the code method any violation on the part of the various individuals who came under their observation. These reports were compiled and put out in the form of bulletins, and in addition thereto, bulletins were originated by the chief "keeper of the golden silence" at least every other day for a period of approximately two weeks. After that time bulletins were published from time to time as deemed advisable. Mr. Chapman reports that judging from the comments received from patients the plan is working out successfully and far beyond the fondest hopes of the organizers. An editorial based on this method of eliminating unnecessary noise was presented in the July, 1921, number of THE MODERN HOSPITAL, and Mr. Chapman promises that a summarization will be presented to the readers of this magazine after the plan has been in operation for one year.

Dr. Nuzum of Santa Barbara Reads Paper

One of the visitors from the Pacific Coast, and one who presented a very interesting paper before the Joint General Session of the Conference on Hospital Service and the American Hospital Association, was Doctor F. R. Nuzum, of Santa Barbara, Cal. Doctor Nuzum is chief of staff of the Santa Barbara Cottage Hospital, which institution as now organized, represents an attempt on the part of a number of the wealthy citizens of that city to provide as complete diagnostic and treatment facilities as can be had anywhere.

To this end the Cottage Hospital was taken over in 1918 and medical men of recognized position were brought into Santa Barbara from various parts of the country, being employed by the hospital on a salary basis from $3,000 to $10,000 per annum. The physicians also have a percentage interest in fees from patients—flat fees being charged by the institution. The resident staff of six physicians functions as a group and the most advanced ideas of group diagnosis and treatment are in effect.

The original Cottage Hospital consisted of a main building of fifty beds, to which there have been added under the new plan three wings, each accommodating a separate department. Additional construction is contemplated for the near future because the present facilities are inadequate to meet the demands.

A plan covering many years of growth has been worked out by the trustees, staff, and hospital consultants and the present success assures an ultimate development of 400 beds.

Has Exclusive Metabolism Department

Among the unique features of the service is a department devoted exclusively to metabolism, in which considerable research work is now being carried on—the expense in part being met by the Carnegie Corporation of New York. The cooperation of the Carnegie Corporation is extended chiefly for the purpose of demonstration—it being deemed desirable to ascertain in what manner and to what extent complete diagnostic and treatment service for metabolic diseases can be developed in the smaller hospital of this type.

Dr. John Bresnahan, formerly associated with the American College of Surgeons, and some years ago one of the assistant administrators of the Massachusetts General Hospital, attended the Conference this year in his capacity of superintendent of the Bridgeport (Conn.) Hospital, an institution of 275 beds. He contributed much to the success of the meeting, and especially did he arouse interest and comment in connection with the problem of procurement of good material for nurses' training schools, by showing a very interesting film of the life of a nurse in the Bridgeport Hospital. Through the use of this film and by other means of publicity Doctor Bresnahan has stimulated interest in nursing as a profession, with the result that instead of a shortage of applicants for the nursing school, it now appears that he will have a waiting list of very desirable material.

Nurses Taught Practical Psychology at Bridgeport

This institution, by the way, is installing in its training school a course in practical psychology with the thought that it will enable the nurses to make their patients happier. In developing this course Doctor Bresnahan is applying many of the principles which guided him and the other morale officers during the war. In this connection, I would like to recommend to all readers of THE MODERN HOSPITAL a recently published book of Colonel Edward T. Munson's, entitled "The Management of Men." The development of morale through systematized psychological stimulation is even more essential in dealing with hospital patients and personnel than it is in military and industrial management.

ILLINOIS FIGURES

The Vocational Summary for May, 1921, contains the statement made by the survey officer of the Illinois State Department of Public Welfare in *Modern Medicine* "that 7,500 persons are discharged every year from Illinois hospitals with handicapping disabilities. A special study was made of 178 cases from two of the hospitals, and it was found that approximately one-third were in need of special occupational readjustment, only a few of the women needed rehabilitation, but a large percentage of the men. One rather striking fact resulting from the investigation was that more were found to be permanently disabled from the medical wards than from the surgical wards.

ECHOES OF THE ATRIUM

HAVE you ever walked alone into a fair, dim place, luxuriant with ferns and with a green light slanting downward? And have you seen the tall, straight trunks of tropic palms rising above you on and on into a leafy sky? And have you smelled the warm, moist air of the forest? Have you? Neither have I. But so in happy anticipation had I pictured the spacious atrium of the West Baden Hotel. The largest in the world! Fern filled! Dimly lighted from above! Breathless with excitement and leaving my cherished suit-case to its little truck, I hastened in.

* * * * * * * *

Have you ever caught your foot on a pile of lumber and nearly fallen headlong, feeling your hat meanwhile slide over one eye? Have you ever smelled fresh paint and shavings? And have you heard the raucous noise of saw and hammer, and seen myriad workmen hastening to and fro? Have you? So have I.*

If you want your institution to run smoothly, oil it, says Dr. John F. Bresnahan. He carries this policy into effect by having a boy make the rounds of his institution once a week to oil all wheels and hinges.

Have you ever seen people clap their hands as they would talk if they had hot potatoes in their mouths? Why not really cheer the victor or the vanquished?

He Must Be a Genius

We heard many things while at West Baden. Many were interesting, some even astounding! We went with an open mind, we came home with an open mouth. Dr. Richardson, superintendent of the Providence City Hospital, told us to be sure to get a "story" from Dr. Peters of the Rhode Island Hospital on his "genius in canning" who, at the head of his kitchen staff, had put up 20,000 tons of fruits and vegetables this year! We swallowed this—figuratively speaking—but being of a naturally skeptical turn of mind, we did a little mathematics later, in the settled calm of our office. We found this to be an allowance of 250 pounds per patient per day. We leave you to communicate with Dr. Peters.

*When the first delegates arrived at the hotel, the exhibition was under construction in the atrium and you passed at your own risk.

Rules for the Elocutionist

If you wish to win your audience at the outset, don't tell a feeble joke, but do one of the following things, all of which were tried and met with approval at the Convention:

1—Set aside two minutes in which everyone may get up and stretch his weary muscles. (Applause.)

2—Suggest that the gentlemen remove their coats. (Much applause.)

3—Announce that your paper will only last five minutes. (General hilarity.)

Early risers at West Baden could always count on meeting Mr. Pliny O. Clark, trudging up the hillside west of the hotel. Faced with the dilemma of faithfully attending all the sessions of the Conference, and of getting much needed exercise, he courageously chose the sunrise hour for the latter. It may be that his occupancy of one of the rooms facing the atrium made his early morning jaunt more a matter of necessity than of courage.

Heard in the Elevator

Superintendent (to a Catholic Sister, in gentle tones): Do you think that you have gained much from your stay here?

Sister (excitedly pleased at his interest): Why, yes, I have gained a pound.

That's Where We Were

Baldwin: Where have you been all morning, Chapman?

Chapman: O, I've been out looking for Lost River.

Mr. Robert E. Neff, superintendent of the Robert W. Long Hospital, Indianapolis, Ind., is looking forward with keen interest to the breaking of ground for the new James Whitcomb Riley Hospital for Children, which will take place on October 7, the poet's birthday. This

Panoramic view of the exposition of equipment and supplies in the

building, he tells us, will be the last word in the construction of hospitals for children, and will give the state facilities for the care of sick children of which it stands greatly in need.

We Hope Not

"Is there anyone sitting here?" said the 240-pound superintendent as she lowered herself gingerly into a chair. I listened—but to my relief, I heard no feeble voice say, "Only me."

When Indiana University opens this fall there will be several new courses in the curriculum for hospital social workers. These courses will cover administrative hygiene and medical social problems. The field of social work will also be covered by a series of lectures, given by prominent social workers.

Dr. Wilkes, of St. Louis, in a soft southern voice suggested that "Knowing how to work the public is the thing. Pour on the molasses; it catches more flies than vinegar. Give 'em plenty of soft soap." They will need plenty of soap after the molasses!

Weren't You Surprised?

"It is not surprising that hospitals have multiplied with surprising rapidity." Oh, come now, you surprise me! Ask Mr. Edison if we are not always surprised at surprising things—else why are they surprising?

Dr. George O'Hanlon, medical superintendent of Bellevue Hospital, New York, tells us that they are now having weekly band concerts in the quadrangle of the hospital. This treat is due to the generosity of the city fathers.

Warner: Did you notice a falling off of attendance at these last meetings? Perhaps the program *has* been a little too crowded.

Superintendent (sadly, as if he had lost something): It's not that, old man; Brown's is open.

Superintendent about to get on train suddenly clasps his hat more firmly on his head and starts running back to the hotel.

Friend (excitedly): Hey, what's the matter? Did you forget something?

Superintendent: I forgot to tip the president of the company who passed out my key every night.

Why do we, when we go to a convention, always "congratulate ourselves" on some subject or other? And, moreover, why does this invariably get a laugh?

The Detroit Welfare Commission was well represented at the Convention, three out of five of its members being present. They were Dr. Wadsworth Warren, Dr. Stewart Hamilton, and Mr. Thomas E. Dollan.

"Well, did you come away from the Convention with any questions unanswered?"

"Yes, there was one thing no one could tell me."

"No, what's that?"

"Where the music went from that little hand-organ the man was playing up in front."

We were always under the impression that Mr. Pliny O. Clark was ecclesiastically inclined. His election last year to the presidency of the Protestant Hospital Association deepened this impression, and we were finally convinced when we discovered him surreptitiously attempting, on Sunday morning, to organize a Hospital Superintendents' Adult Bible Class from among the early arrivals at the Convention.

MacEachern—"What news from the University of Michigan, Springer?"

Springer—"O, I am trying hard to maintain my normal rate of mortality."

Dr. John Bresnahan, now superintendent of the Bridgeport General Hospital, Bridgeport, Conn., believes in going out into the highways and byways, if necessary, to carry the message of nursing as a worth-while profession. After his dramatic moving picture of the training of nurses has been syndicated to the cities of Connecticut, Dr. Bresnahan plans to carry the message to the rural communities of the state by automobile. So long as the Ford will run, the picture will be shown wherever there is a barn to attach a sheet to and a crowd to gather around.

By a Staff Photographer

Atrium taken from the balcony above the orchestra platform.

WHAT SOME OF THE DELEGATES THOUGHT OF IT

THE first thing we stay-at-homes say when anyone returns from a trip or any experience of interest is, "Well, did you have a good time?" and "How did you like it?" Or, even if we have been along, on meeting our friends again we all spontaneously ask, "What did you think of it?" And so THE MODERN HOSPITAL asked the superintendents at the West Baden meeting what they thought of it, and these are some of the replies. Perhaps they will help those who were not there to gain an intimate insight into the meeting, and those who were there can compare notes with these opinions.

Pliny O. Clark, of Denver, wrote: "The meeting at West Baden this year has proven very helpful to me, first because the sessions were not too long and one did not get overtired, and second, because those who presented papers were recognized leaders and could speak with authority. The half day of recreation, in which to catch one's breath, as it were, was missed. Still there were excellent opportunities for recreation in the few moments that could be spared.

"The commercial exhibit was the best yet, and those in charge seemed to have the dominant spirit of the Convention, 'service.' The round table sessions were very profitable, because they were conducted in a quiet, orderly manner, without jangling, or allowing one person to monopolize the floor. One missed the religious note in some of the sessions, which to many is always associated with the highest type of scientific hospital service. In closing, we should be especially grateful to the officers and trustees of the Association for the great amount of work required to make possible this gathering together."

More Round Table Discussions Profitable

James U. Norris, superintendent, Women's Hospital in the State of New York, reported that the meeting had been more profitable to him than any previous one. "Distinct gain, I believe, has been made in limiting the number of papers, and giving more time to round table discussion. The report of the committee on hospital forms is of great value, it alone being worth the institutional dues of any hospital. I have only one suggestion to offer, that in future meetings the sessions be limited to two per day, as there is a limit to the amount of information an average individual can absorb in twenty-four hours."

"The Convention this year," said Dr. C. W. Munger of the Blodgett Memorial Hospital, Grand Rapids, Mich., "was unusually successful. The fact that there were no hospitals to visit was a relief, although perhaps the Association should not repeatedly meet in such a place. It would seem the trustees should seriously consider holding the Convention a month later to escape the discomfort of tropical weather such as prevailed at Cincinnati and at West Baden."

Michael M. Davis said that he was very much impressed at the Convention with what several superintendents of the smaller hospitals are doing in starting and running out-patient departments. The work of Dr. S. G. Davidson of Rockford Hospital, Rockford, Ill., described in his paper, is a good example of this. There is no health problem in the country more important than the better medical service to be given to people in the small communities, and what Dr. Davidson and others like him are doing is a great contribution in this direction.

A partly adverse criticism came in from George E. Halpern, Lebanon Hospital, New York City. He did not feel that the Convention was as helpful this year as usual. He thought that more round tables were needed, so organized that questions and answers would be prompt, fewer people could talk off the point and people in their first year of hospital work tell about the wonderful work in their hospitals. "Many people's time was wasted because of bad acoustics," said Mr. Halpern. "We could not all get within five feet of the speaker. How about sounding boards next year? As a get-together with old friends the Convention was excellent. The exhibit also was very helpful. Night meetings should be abandoned, two extra days being taken in by the Convention if necessary. I consider the time and place were most unfortunate choices, and I cannot emphasize this too strongly. The heat was unbearable and the fact that there were no hospitals to visit was a great drawback."

Elmer E. Matthew, Wilkes-Barre City Hospital, Wilkes-Barre, Pa., felt that he gained a great deal of valuable information from both the meetings and the exhibit, and his only criticism was that due to the time of year, the heat was so oppressive.

Miss J. C. Quimby, R.N., Home Hospital, Lafayette, Ind., said that she had received great benefit from the Convention.

Many Praise Exposition

"I have received some very good ideas, said Clarence T. Johnson, superintendent, Washington Boulevard Hospital, Chicago, "made a lot of new acquaintances and through the round table discussions have learned a great deal of what other people do and think concerning various hospital problems. The exposition was very good and brought out some very modern ideas on various hospital supplies, appliances and equipment."

Mr. George Stoker, Municipal Hospitals, Winnipeg, summarized his impressions in the following way:

"I am of the opinion that the outstanding feature of the Convention was the exhibit which covered almost every field of hospital endeavor. More attention should however, be paid to the matter of interesting manufacturers of building materials and equipment in presenting their wares.

"Every hospital superintendent is interested at some time or another in preparing plans for a new building and wants to feel that he is posted and up to date in what is the latest in flooring, wall finish, painting, electric fixtures, incinerators, etc. Some such firms have exhibits, but there are many others with lines which many superintendents have not had an opportunity of inspecting and familiarizing themselves with, other than from catalog illustrations.

"Round table discussions are the best way of gleaning and imparting ideas, but they should be based on papers previously prepared by those supposedly most familiar with the subject. Copies of said paper should be printed in pamphlet form and distributed the day prior to the discussion on that subject. In order to further stimulate active discussion, a second person, equally familiar with the topic, should be called upon by the chairman to take the lead in it. Dr. MacEachern adopted this method with marked success and benefit to others."

Chairmen More Carefully Picked?

"More particular attention should be paid to the selection of suitable chairmen, who will carry on the meeting in a business-like way, keeping members from reminisc-

ing about falling plaster, etc., without being able to cite the cause, and voicing other complaints without indicating the remedies applied. These chairmen should be men or women who will keep speakers to their subjects, and they should also have executive disciplinary authority in respect to having the members there in time for the commencement of proceedings and seeing that they maintain proper silence during the session so that all may get the full purport of what is said.

"The management of the hotel selected should be required (in so far as it is in his power to control it) to see that a quiet zone is maintained in proximity to the convention hall during sessions, and should not allow automobiles and trucks to cavort around the building with 'cut-outs' open.

"In selecting the place for future meetings it should be borne in mind that the majority of superintendents have only the opportunity presented by the Convention to visit and inspect other hospitals, and that large cities are more likely to have an assortment of institutions varying in size and type than small ones."

"The 1921 Convention has been most helpful in many ways," said Dr. Frank Clare English. "Beginning with a program of the Protestant Hospital Association on Monday, and continuing the discussions of the American Hospital Association through the week, the speakers presented strong, inspirational, entertaining, and instructive addresses. The committees having all preparations in charge are to be commended. The social opportunities, the unequal exhibits, and the consideration of vital hospital subjects are sure to produce a reaction auguring a higher degree of efficiency in everyone who attended."

Cordiality Never More Marked

The personal element is emphasized by Mr. Robert E. Neff, Robert W. Long Hospital of Indiana University.

"I think we will all agree that one of the most attractive and helpful features of the Annual Conference of the American Hospital Association is the opportunity for personal contact which is afforded. Acquaintanceship and personal contact with hundreds of hospital workers with a common pursuit and interest are sure to result, not only in a happy and pleasant social period but one of tremendous benefit which will tend to increase the usefulness and efficiency of those attending the Conference.

"It seems to me that the outstanding feature of this Conference is the fine spirit of cordiality and acquaintanceship which has prevailed. I believe the lack of outside attractions is largely responsible for this. Instead of leaving the Convention headquarters during the recess periods of the Conference, delegates have remained about the hotel and enjoyed the happy communion and fellowship of others.

"We should not fail to mention the splendid commercial exhibits which have made a most favorable impression on all present, also the courteous and helpful spirit shown by the persons in charge of the exhibitors' booths."

Interchange of Ideas Valuable

Dr. M. T. MacEachern, of Vancouver, B. C., gave an enthusiastic account of what he gained from the meeting.

"My impressions must of necessity and in all sincerity be characterized by words of praise and eulogy for our board of trustees and our worthy executive secretary in their splendid arrangements and in the most excellent program presented. When I arrive home on the Pacific Coast next Wednesday I will have traveled about 5,000 miles, and I can say without hesitation that there are numerous features which even singly would compensate for the distance traveled.

"One of the greatest advantages for the Association and each of ourselves has been the fact of being housed together here as one big family, thus having much better opportunities for acquaintanceship and interchange of ideas than formerly.

"The exposition is the largest and best ever gotten together. Every delegate or visitor can see anything and everything in hospital equipment at first hand; indeed this exposition is a liberal education in itself. I cannot forbear mentioning the courteous attention given the visitor at each booth by the representatives of the best firms of the United States. I hope that every person attending the Convention visited each booth in turn, and at least met the representative and left his address.

Valuable Information from Booths and Exhibits

"In the atrium were several booths giving valuable information regarding hospital social service, dispensary activities, nursing, and many other branches. Each booth was under competent direction and the information came from experts. I cannot pass without mentioning the Hospital Library and Service Bureau. I consider it one of the greatest achievements and developments in hospital work in a remarkably short period. Here every phase of hospital information is collected, indexed, cross-indexed, and finally analytically indexed, and made available for hospitals, health workers, investigators in all fields of research along hospitalization and health lines. It will be one of the greatest boons to our small rural hospitals, particularly this accessible information sent or given promptly free of charge. It will be the basis of hospital research in the future.

"The program this year has been a very democratic one and a great success. The papers have been excellent and full of real information. The round table conferences have aroused a new interest in the Association through the practical and communal discussion of so many intricate problems. Everybody wanted to and most of those present did speak. In short the program has been the greatest clearinghouse for our problems that we have ever had.

"We could not leave West Baden without expressing our very deep gratitude to the Indiana Hospital Association for their kindness throughout the Convention.

"The trip has been one of great pleasure and enlightment to us all, and we go back with renewed energy and enthusiasm to put real things over in our hospitals."

A newcomer, H. F. MacGregory, Houston, Texas, voiced his approval: "This is the first meeting I have attended of the American Hospital Association and I am very much pleased with the work being done by the organization, and consider it a very profitable trip for the trustees of the Herman Hospital Estate that were in attendance."

Mr. Gilmore Mentions Good-Fellowship

Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, said: "This Convention is marked by a greater spirit of good-fellowship than has prevailed at some others. This is to the advantage of the Association. The largest measure of profit comes to many, not through the papers read, but through friendships formed and renewed, and through the relation of experiences which take place in the little groupings about the lobby.

"The commercial exhibit is the best of any in the history of the Association. Its setting in the wonderful atrium of the hotel could scarcely be improved.

"Let us hope that in future the natural climatic conditions of the place selected for the Convention will determine its whereabouts."

"I think the trip to this Convention is well worth the money spent, and I am delighted with it," said Robert Jolly of Houston, Texas. "I have gotten much help, especially from the round table and the displays have saved us money because I have found many money savers.

"I have but two suggestions to make, first, there ought to be some way arranged to enlarge our acquaintances. The only way I have seen to do that is to introduce yourself to others. I like to do that, but I know there are dozens who can't do that and they go away not knowing any more people than when they came. I would suggest that at each session during the day the chairman say, 'Friends in order to rest ourselves and get better acquainted, let everyone stand a moment, turn around and introduce himself to the one just behind him and then to the one on his right.' That would put everyone in good humor and help us to make some helpful acquaintances.

"Second, the south is not well enough represented. I counted seventy people who are officers and committee men and of that seventy only four are from the southern states. If you want to enlist the South, use them."

Dr. George S. Stephens of the Winnipeg General Hospital was the last delegate from whom we heard: "Situated as I am in a somewhat isolated field geographically, it is practically a necessity that I go to the Convention. The formal papers are less interesting than the other features to me, for these can be read later, but the discussions and round tables are of particular value. In this latter connection it seems to me that the most satisfactory method is that by which the questions are printed beforehand so that more than one session can be covered during a given period. As a suggestion, I should like to see the 'Transactions' printed at once, with all discussions, instead of waiting almost a year."

RECREATION

NEVER more than at West Baden were we grateful to the old and hoary etymologists who pondered over our language. Grateful for their happy choice of the word "recreation." Created again! And we were created again by that beautiful country and the succession of perfect September days.

Golfing, tennis, baseball, horseback riding, hiking, motoring, swimming—each one hastened to his favorite sport in the moments left for sport. We were not all nervous wrecks or tired out business men when we arrived at West Baden but we had most of us forgotten that hillsides could be so green or goldenrod so golden. The golf course was very "sporty," as true golfers say, and offered infinite opportunities for making long graceful drives, and losing balls. The golf tournament with numerous prizes donated by the exhibitors was a great success inasmuch as every one entering had to get a prize, the latter being as numerous as the former. The silver loving cup was won by Mr. H. C. Genter.

Tennis was a little less popular though there were good courts on the grounds near the baseball field. Baseball came in for its share of publicity when the exhibitors challenged the "Plutos." One superintendent who had placed her bet on the Plutos was rather surprised to arrive and find them as black as night.

The horses were fine thoroughbreds and not only the little sign in the hotel lobby "100 miles of trails through the woods. Cool all day long," made one long for the open road. Then there was hiking to various spots around the country—or for those who wished to cover more ground there were motor cars. Swimmers of the party went off to French Lick in the cool—no, the heat—of the late afternoons when the meetings were over, and brought back enticing reports of the swimming pool there.

We will pass over the indoor sports, except to mention in passing the badger fight which attracted a large crowd. According to the Daily Bulletin from which we get our information on this subject it is probably still in progress.

Perhaps we should mention the bowling and billiards which were offered in a palatial white building in the midst of the formal garden.

The rise of Lost River was one of the spots which could be reached by motor or on horseback

Some delegates enjoyed—or rather took—an early morning walk around the covered bicycle track between glasses of "No. 7." This might be called indoor or outdoor sport—or perhaps it hardly comes under the title at all.

It takes so few words to tell of the recreation offered at West Baden and so many have been devoted to recording the benefits and inspiration of the meetings. Perhaps this is an unfair proportion. The delegates will long remember ideas presented at the Convention—but will they soon forget the views over the hills, the mists rising in the morning—the whole inspiration of the outdoors?

SPECIAL FEATURES AROUSE KEEN INTEREST

LIBRARY AND SERVICE BUREAU EXHIBIT HAS MANY VISITORS

THE exhibit of the Hospital Library and Service Bureau was an active spot at the Convention. Many visitors came and went—away enlightened.

The first thing to catch ones eye on entering the booth was an array of hospital plans around the walls. These —over 300 of them— were arranged on racks, and classified according to the type of service represented so that persons wishing to see plans of a general hospital for example, could be directed to the proper rack. Here many architects, trustees and superintendents spent a very educational hour. Their attention was also called to the other material found in the library files on such subjects as lighting, heating, etc.

Another feature of the exhibit was the display of the indices of hospital magazines which the library is making. This author, title, and subject index is made on the dictionary plan with numerous cross references so that inquiries may be answered with increasing ease. The indices at present cover only the last year of THE MODERN HOSPITAL, *Hospital Management*, and *Hospital Progress*, but the work is progressing rapidly backward.

Bibliographies which are being prepared by the Library were also exhibited. These bibliographies have been made on thirty-two subjects and more are in progress of completion. The bibliographies consist of a list of magazine material—not only from hospital magazines but from all medical journals. The library was busy "taking orders" for bibliographies on other subjects. Additions will be made from time to time keeping the bibliographies up to date, and all of them will be loaned on request to those desiring this service.

A complete list of hospital architects was also displayed. The architects are arranged geographically, with a cross reference to hospital plans.

The "package libraries" aroused a great deal of interest at the exhibit. These are folders containing clippings from the various hospital journals; excerpts from letters from authorities; pamphlets on the subject; lists of magazine articles other than those represented by the clippings; and constitutions and by-laws of institutions when apropos. These will be loaned on request and may be kept for three weeks. This "package library" idea was conceived originally to help people in rural and isolated communities but people in cities have also been glad to get the information in so concise and convenient a form.

An author and subject index of all pamphlets of interest to hospital workers of all kinds was also on display. Sample sets of record forms, all those used in a particular hospital being bound in one folder, were also at the exhibit, and these will be sent out as a package library on request.

HAS YOUR HOSPITAL A VENEREAL DISEASE CLINIC?

The aim of the venereal disease exhibit at the Convention was to show that any hospital, no matter how small, should, and what is more could, have such a dispensary within its walls. The exhibit was arranged by the Committee on Out-Patient Work of the American Hospital Association. This committee consists of John E. Ransom, Michael Reese Dispensary, Chicago; Dr. Robert J. Wilson, Health Department Hospital, New York City; and Dr. Alec N. Thompson, director medical activities, American Social Hygiene Association, New York City. The fact that Dr. Thompson is connected with these two agencies for venereal disease control has brought about a closer cooperation between them, and during the past two years the two organizations have combined their efforts.

The committee has two aims, one is to promote the development of out-patient service in hospitals and dispensaries, the other is to correlate this work with that of the various public health movements, one of the most significant of these movements being that for the control of venereal disease.

The Association has gone on record as favoring the

By a Staff Photographer

The exhibit of the Hospital Library and Service Bureau, one of the centers of interest at the Convention

establishment in general dispensaries of clinics for the treatment of venereal disease and the establishment of facilities in general hospitals for this type of patient needing hospital care. Since the Association does not wish to limit its service to those attending the Convention it has arranged to have Dr. Thompson available as a consultant throughout the year, and questions relating to institutional medical service for venereal disease patients will reach Dr. Thompson if addressed to the Service Bureau on Dispensaries and the Community Relations of Hospitals, 15 W. 43rd St., New York City.

The exhibit was arranged with the idea of showing the important features of the admitting room with social service and follow-up work; the waiting room where the

The venereal disease clinic exhibit of the committee on out-patient work.

patient's time is spent for his own instruction through wall display and pamphlets; the history taking and examination room where every patient should receive a complete physical examination; the treatment rooms for gonorrhea and syphilis; and the laboratory which the committee believes to be absolutely essential.

An important part of the exhibit was the complete set of forms used in social service, admitting, registering, instruction and history taking which were collected from hospitals all over the United States and Canada. These were made accessible by being bound in about 150 folders. There were also on display floor plans and photographs from various clinics in the country showing the different possibilities of layout.

The committee had gathered together many practical suggestions in regard to clinic methods and treatment and had these bound in folders which it distributed to visitors. Members of the committee were available for consultation on special problems during the Convention.

DISPENSARY COMMITTEE HAS GOOD EXHIBIT

Among exhibits in the convention hall which attracted attention was that of dispensary work, provided by the committee on Dispensary Development of the United Hospital Funds, New York. This included a number of charts showing, for instance, a plan for the admission system of a dispensary, with sample forms for use in admitting patients and diagrams of arrangement of space. Other charts dealt with dispensary statistics and records. Another set of charts pointed out the need of pay clinics for the middle classes. Many people who are not subjects of charity but who are below the self-supporting home, have nevertheless too small means to pay for expensive medical treatment, particularly by specialists. These people fall in between the private office of the specialist and the charitable clinic, and the only way to provide for them seems to be the pay clinic, charging fees which meet the cost of service and give financial compensation to the clinical medical staff.

CONVENTION HAS DISTINGUISHED FOREIGN GUESTS

One of the interesting and greatly interested visitors at the Convention was Mr. H. C. Tsao, who is the executive secretary of the board of control and of the executive committee of the medical school and hospital at Changsha, Central China.

Some ten or twelve years ago the Medical Missionary Association, for the purpose of organizing the educational and medical work of the country, established four grand divisions, namely, the North, East, South, and Central divisions. The medical school and hospital with which Mr. Tsao is connected are recognized as the medical center of the Central division. The general educational work of the university, with which the medical school and hospital are connected, is supported by the Yale Foreign Missionary Society, an organization of Yale graduates, and the medical school and hospital work is supported by the earnings of the hospital and by contributions from the Chinese themselves, with some assistance from the Yale Society and the China Medical Board. All of the churches of the province in which the university is located have been asked to join in supporting the work, and an effort is now being made, Mr. Tsao informs us, to get all the universities in this country to join Yale in supporting the University of Changsha, to the point where it will be able to give all the courses that are to be had in any fully developed university. Mr. Tsao was greatly impressed by the scope and varied activities of the American Hospital Association, and felt that the Convention more than made his trip from New York worth while.

Mr. H. C. Tsao, of the Yale China Medical School and Hospital, who found much to interest him at the Convention. He was accompanied by Dr. F. C. Yen, the principal of the school.

Mr. Tsao was accompanied by Dr. F. C. Yen who is principal of the Yale Medical School and Hospital. Dr. Yen considered that the journey from New York City to West Baden to attend the convention was amply compensated by the benefits in ideas and personal contacts which resulted.

The Chinese visitors both expressed surprise at the variety of the exhibits on display and were very much pleased with the exposition.

REPORTS SUBMITTED TO THE CONVENTION

REPORT OF THE BOARD OF TRUSTEES

THE trustees have held four meetings since the last report. The first and second were in Montreal October 4 and October 8, and all trustees were present at each of these meetings. The third and fourth meetings were called in the office of the Association in Chicago, January 10 and June 20. At the first meeting on January 10 seven trustees were present and at the meeting on June 20, six trustees were present.

At each of these meetings the financial and other reports covering the conduct and routine work of the Association were presented and considered. In addition there were the following special actions:

At the first Montreal meeting various reports to be read before the Association were presented and considered.

The application of the Wisconsin Hospital Association to become a geographical section was presented in proper form and it was voted to approve the application and to extend recognition to this association as a geographical section.

Authorize Bureau on Hospital Social Work

At the second Montreal meeting called on October 8, the new president, Dr. L. B. Baldwin, presided. At this meeting the Service Bureau on Hospital Work was authorized, and funds appropriated for its maintenance. The employment of Miss Ida M. Cannon as the director of this Bureau was also authorized.

The report of the director of the Service Bureau on Dispensaries and Community Relations then came up for official action. General approval of the work of this Service Bureau was expressed and the necessary appropriations for continuing it for the next year duly passed. This Service Bureau was by vote authorized to make local community surveys to determine the community needs for hospital service as well as surveys made to investigate the community relations of any particular hospital. Other policies and routine procedures for the conduct of the Service Bureaus were determined.

At the meeting held in Chicago, January 10, the first business was the consideration of the time and place for the holding of the 1921 Annual Conference. After considering the advantages and disadvantages of several places it was decided to hold this Conference in the West Baden Springs Hotel, West Baden, Ind.

After hearing a representative from the office of the Surgeon General, United States Public Health Service, on the question of opening a greater number of civil hospitals to cases of pulmonary tuberculosis, the following resolution was adopted:

WHEREAS, In the past, not all general hospitals have accepted tuberculosis, and

WHEREAS, It has been demonstrated in a number of such institutions that this class of case may be admitted into separate wards without detriment to other patients, and

WHEREAS, Both for humanitarian reasons and for purposes of instruction, there is need for a change of policy in this regard, then be it

RESOLVED, That the trustees of the American Hospital Association recommend to the American Hospital Association that it pass a resolution to the effect that it recommend to the hospitals that separate wards be established in general hospitals, where possible, for the care of such patients.

The resolution of the Michigan Hospital Association requesting recognition by the American Hospital Association as a section of said Association in and for the State of Michigan was presented. By vote the trustees granted this recognition and established the status of the Michigan Hospital Association as the Michigan Section of the American Hospital Association.

Consider Application of Protestant Association

The trustees considered at length the petition requesting recognition of the Protestant Hospital Association as a section of the American. As the constitution of the latter provides only for departmental and geographical sections, this application could not be acted upon favorably. The resolution of the trustees was as follows:

VOTED, That as the constitution of the American Hospital Association has no provision for the creating of a section as requested by the Protestant Hospital Association, the request be refused with the understanding that any propositions for cooperation with said Association will be given consideration if received.

By vote the trustees expressed final approval of the report made by the Committee on Hospital Social Service and authorized its circulation as a pamphlet of the Association, and bearing the approval of the trustees.

The trustees expressed their opinion that study of the education and training of the hospital social worker was at this time to be desired, and authorized the executive secretary to attend any meetings called for this purpose, to act for the Association, and to accept in the name of the Association the responsibility for carrying out such a study; provided that this acceptance shall not imply a special appropriation from the funds of the Association, that the final appointment of the committee shall be made by the president of the Association, and that no report or plan of action shall be published as the result of the work of such a committee unless and until the same has been approved by the trustees.

By vote the trustees approved the proposed plans for the study of hospital floorings as presented by the executive secretary, and authorized the acceptance in the name of the Association of a gift of $1,000.00 to establish a fund to be used exclusively for this purpose.

Mr. F. E. Chapman, superintendent, Mount Sinai Hospital, Cleveland, Ohio, was duly elected the chairman of a committee to carry on this work.

The trustees authorized and instructed the executive secretary to edit the extemporaneous discussions at the 1920 Conference, and publish the same without submitting them to the members.

New Departmental Sections Authorized

Two new departmental sections were authorized—one on hospital dietetics and one on state or psychopathic hospital work, the section on dietetics to present a program at the Annual Conference. The time did not seem right for the development of a program on psychopathic work.

By vote the trustees expressed the desire to receive application from the hospital associations of the Provinces of Canada for recognition as geographical sections of the American Hospital Association.

The great value of routine autopsies to advance the professional work in hospitals, and the fact that at present the percentage of autopsies performed in many hospitals is far too low was discussed. The following resolution was unanimously adopted:

WHEREAS, It is universally agreed that a determination of the cause of death by autopsy contributes greatly to the advancement of vital statistics, and, in a large number of cases, is extremely advantageous to the family of the patient for the protection of social rights and for hygienic purposes and that the practice of routinely securing autopsies invariably results in bettering the medical work of the hospital, and

WHEREAS, The percentage of autopsies secured in many hospitals is so far below others that it can be explained only by indifference or neglect, be it

RESOLVED, That the trustees of the American Hospital Association do urge upon the Association, as a body, upon each member individually, and upon hospitals in general, the necessity for diligent action on the part of physicians and surgeons practicing in hospitals to make every effort to secure the performance of autopsies in all cases of death in the hospital, and that hospital executives be held responsible for securing the performance of an adequate number of autopsies in their institutions, in order to insure the maximum benefit in the medical work of the institution.

At the meeting held in Chicago, June 20, the first special business transacted was the approval of an offer from an interested individual to provide funds to carry out a study of the clinical and administrative records and record keeping in hospitals. This fund was generous enough to provide for a full-time secretary of the committee so that the work could be rapidly pushed. This committee is reporting to this Convention.

Pass Resolution on Bed Care

After a discussion of the far-reaching importance of the admission of venereal disease patients into hospitals, as well as the practical difficulties incident to these admissions the following resolution was passed:

WHEREAS, It is now generally agreed that only a small percentage of venereal disease patients need bed treatment at any stage of their disease, and

WHEREAS, It is now established that bed treatment for the few who do need it is of short duration and benefits not only the patient but distinctly lessens a public health menace, and

WHEREAS, Knowledge of venereal disease is now so general that the psychology of all attendants can be depended upon to prevent contagion from all known cases of venereal disease, be it therefore

RESOLVED, That we, the trustees of the American Hospital Association, do hereby urge all hospital authorities to give consideration to this matter—to the end that all general hospitals shall admit venereal disease patients as other patients and enter these diagnoses as other diagnoses on histories whether primary or complicating, and also develop sufficient dispensary service to provide care for the ambulatory cases and the ambulatory stages of the cases treated in the hospital.

The final outline of the proposition for a committee to study the education and training of the hospital social worker was presented as developed by the negotiations authorized at the previous meeting of the trustees. The proposition was approved and the work will be carried on with financial support contributed from several sources. The time, the traveling and other expenses of all members of the committee employed by organizations will be contributed by these organizations. Certain items of expense will be contributed by the New York School of Social Sciences and the rest of the fund required for special expenditures has been appropriated by the Russell Sage Foundation. The expense of organization and the overhead will be carried by the Association.

The desirability of a special committee to study the formal relation between states and cities to the hospital and dispensaries located therein was discussed and the following resolution passed:

RESOLVED, That the president be and hereby is authorized to appoint a committee of five to study the formal relation between states and cities to the hospitals and dispensaries located therein, and make due report to the Association.

By vote the trustees expressed approval of the distributing of exposition supplements as published by hospital magazines and containing complete programs from the registration booth at the Annual Conference.

It is the opinion of the trustees that the Association is making marked progress. The policy of service to the individual hospitals and the field in general has become the primary, the guiding and the fundamental one. The Association has reached the stage where it needs most of all intimate contact with and an official recognition by more hospitals.

The recognition needed is the formal one—of membership. The Association must officially represent more hospitals.

The more intimate contact needed is such as comes through use of the service of the Association and its service bureaus. By this both the Association and the hospital will benefit.

We ask that every member and hospital worker present undertake during the coming year to make a distinct contribution to the Association in each of the above lines.

REPORT OF THE EXECUTIVE SECRETARY

The reports of the trustees, of the treasurer, of the membership, of the standing and the special committees and of the service bureaus have given you the important accomplished facts concerning the work of the Association as done in the past year. It is, therefore, proper that this report make critical comments thereon and tell you of that which was not done or not well done, of the things that are as yet only plans or hopes, and to forecast for you a future of attainable progress.

Membership

The membership has grown somewhat in numbers in all classes as is shown in the report of the Membership Committee. But it has grown more in ways other than in members.

It is evident that the hospitals now regard their institutional membership as of greater value. Only $295.90 is yet unpaid of the 1921 dues and the total effort expended has been to send quarterly bills. Not a letter has been written. This includes the recent applications on which bills for dues have not been sent. It is better recognized than heretofore that such membership is a contract between the Association and the responsible owners of the hospital.

There has been temptation to start an active correspondence campaign for institutional memberships. But the contrast in the attitude toward the Association between some of the older members and all of the newer members was too striking to permit haste. The basis of this is the fact that the older members joined to help the Association in its organization and the newer members have joined to help themselves in their work. Some of the earlier members are still primarily helping the Association but the latter are now primarily getting help from the Association.

Perhaps this can not and should not be changed and the Association certainly did need and still needs and appreciates highly the help, but it makes one hesitate to interfere with the present situation. The new members we are now gaining mean too solid a growth to risk any change. The new institutional members are coming in largely as a result of some service from the Association or contact with other members, and from the first they ask enough service from the Association to answer for themselves the question as to "what they are getting for their membership dues." Would a membership campaign produce so healthy a growth?

The Association can never compel any hospital to ask or use our services or to do anything. We can only offer, and by bulletins and otherwise acquaint the hospital with facts, arguments and the ways of other institutions. But we are naturally surprised when a hospital does not find

even a question to ask of the resources of the Association, and naturally wonder if that hospital as yet realizes the recent developments, and that the full time executive secretary—once so important—is now only a very small part of the organization active and available throughout the year.

While the Personal Membership lists are somewhat larger in number, they are markedly different in quality. The quarterly bulletins keep the addresses correct. Inquiries and correspondence keep the record up to date. Regular quarterly bills and a more active interest in the Association keep the dues better paid. Personal members are in the main appreciative as to the value of the service available to them. This adds value in the memberships to us.

The striking feature to be mentioned is the greater number of trustees taking out personal membership. Institutional membership was expected to secure their interest and enable the Association to reach trustees. Perhaps it has had some effect in this way, and the increase in personal membership is a result of this. But it is now quite clear, and perhaps logical, that many trustees wish to receive their information directly to be used for the guidance of the hospital rather than that it be received through the hospital and used for their guidance. The educational service of the Association to trustees must develop much and soon.

Nothing is so disheartening as to receive an official hospital check paying the personal membership dues of the superintendent. The failure of the Association and the attitude in that hospital is so evident. We have the five dollars and that is about all. We do not have an active personal member in any sense of those words. We do not have one more hospital feeling itself a part of or presuming to participate in the activities of the Association. We have only ourselves to blame for this—the Association has miserably failed to get over to that superintendent the basis of our work and our aims. The money is without question useful, but money alone will never make this Association able both to serve and to lead. The other factors absolutely essential are acting brains, thoughtful policies and human effort, and these do not come with official hospital checks paying personal memberships.

Finances

The income from personal membership is growing, but the cost of printing and other services to personal members as individuals is amounting to as much as the dues. This is as it should be. Personal memberships can not and should not support overhead or advancements.

The larger increase in the income from the institutional membership is supporting the development of the organization of the Association *as a machine to perform service* to them as individual hospitals and to the field. The opportunities to extend and to better this service in a thoroughly wise and conservative way are, however, developing faster than the income grows.

We need more money. The raising of a fund to make an extended service possible at once has been proposed. The returns from such an investment in the advancement of the hospital field certainly would be remarkable. On the other hand why is it taking the hospitals so much longer than other fields to realize that the benefits from organization are certain and all out of proportion to the cost of any membership dues? Your executive secretary has refused to believe that this will long remain the situation. Why is your hospital not now a member—if it is not? Can we not do a little more for ourselves before we appeal for aid?

Funds to support special investigations have become available as rapidly as definite propositions have been developed and we were able to show a fitness for the work. This will continue. As the Association becomes stronger and more able to do special work, more financial support for such work will appear.

Annual Conference

The Annual Conference was planned to be of the utmost value to delegates who had come to learn and to get help in the form of facts, figures, and suggestions. Everything was considered in the light of its service value.

The exposition is just twice as large as last year but of many times the value to delegates—if they will take the time to see what is there. As soon as delegates generally realize the possibilities of service to them from the exposition and will make a point of knowing what is exhibited therein each year, our exposition will become the established means of introducing to the hospital field the new and the improvements in equipment and materials. The great value of such an exhibit in connection with each annual gathering, cannot, I believe, be questioned. Whether we get it or not is all up to you and your attitude toward the exposition. The reliable, larger, and the established corporations, which we most desire present, will not come or continue to come into an atmosphere of indifference or toleration. But they will be glad to come to meet users of equipment such as they manufacture, for mutual suggestions, criticisms and discussions.

Policy

The fundamental policy of service to our members and to the field has in the past year become more definite and better understood. It is now more clearly seen as the only policy which fully justifies the continued existence of the Association and progressive growth.

Service

The work of the year has contributed much to the strength and system of our organization for service. It is now evident that it takes time to get a service bureau into action, or the Chicago office ready to handle a new line of inquiries, but the past year has been thus utilized. Each of our bureaus has worked out affiliations and connections with other organizations which eliminate duplications and which secure routine assistance of an expert nature. Each is, therefore, now better able to give final authoritative opinions which are in fact a consensus of expert opinions. It takes time to develop this organization. It also takes time to make this generally known and to establish the subconscious suggestions whereby questions are promptly asked of the bureaus instead of some acquaintance.

The Service Bureau on Dispensary and Community Relations has now become quite active and filling the function for which it was designed. It has been pleasing to note the high personal qualifications and the satisfactory work done by the persons secured by the director to make the field studies in the surveys made. The surveys to be made under the direction of this bureau will increase during the next year and the Association must soon face the necessity of retaining the service of one or more of these persons throughout the year.

The surveys made by this bureau and listed in its report have done much to advance the prestige of the Association.

The Service Bureau on Hospital Social Work is newer and, therefore, has less accomplishment to report, but it is now ready and able to give you real service—for the asking.

New Bureaus Needed

There is a need for a service bureau organized and equipped to analyze construction problems and give sound advice. We are pleased to believe that there is now at least a possibility of having in the near future such a bureau on construction and one that will be a credit to the Association.

The development of state sections has brought to us the responsibility for acting at least as a clearing house and source of information of state legislation affecting hospitals. We should also be able to assist by dispensing information as to the laws in other states and take active part in combatting such vicious bills as the legal open staff bills.

A compilation and extraction of all existing state laws affecting hospitals is available at a price and at reasonable cost this could be kept up to date. If to this was added a director capable of mapping out a legislative campaign and providing the state association with the legal and other material for the same, much could be accomplished for the hospitals of many states. But the Association now lacks the funds necessary for this work.

Special Committee Active During Year

As the Association has become more active throughout the year the committees have become more active and available to the office and to members for advice, data, and work.

The special committees have been appointed as the need for and the funds to support special work appeared. Five are making progress, or final, reports at this Conference. Their reports speak for themselves. The cost of their work to parties other than the Association will be in excess of $20,000.

The policy of sending timely and useful information in the form of bulletins to institutional members has been continued and may now well be considered a permanent practice. There is constant call and use for these bulletins requiring new editions. Three have now gone over the five thousand mark. It has also become easier to get valuable data for publications in these bulletins.

The quarterly bulletins to personal members keeping them informed as to the Association seems to meet with general approval.

Correspondence is growing. The Chicago office alone expended for postage this year $890.62, compared with $613.96 the year before—an increase of 44 per cent. Much of this correspondence means service.

Next year all the above service will be continued and made better by the normal development of a working organization and, we hope, by greater use.

New features will also be added to the limit of the available funds.

Hospital Library and Service Bureau

The Association is not duplicating the work of the Library but rather using it freely and contributing substantially both to the subject matter filed and to its maintenance. The function of this library maintained by the American Conference on Hospital Service is to collect and dispense data on all subjects related to hospital work without comment or opinion. We ask that members contribute to the collection of information, data, and literature and also use the Library to furnish them with facts. The more it is used the more and better will be the information filed and given out.

Real Situation as to the Association

Perhaps it is appropriate to state here facts and to state them plainly, for all implied criticism is of ourselves.

During the past year your executive secretary has given considerable thought to an analysis of his job and of the Association. The most urgent part of this job right now seems to be principally one of expanding and building up the organization of the hospital field in time to meet recently developed conditions and external forces now impending.

In contemplating the size of the hospital field of the United States and Canada measured either on the basis of dollars or on the basis of the human elements one is astounded. A realization of the importance of it to every citizen of this country as an individual and to humanity in general is overpowering. The need for extension, improvements and help in many ways is pitiful. But a comparison of this field and these opportunities with the strength and the accomplishments of the American Hospital Association makes our failure only the plainer.

I know I have worked as I know my predecessors have worked—hard to the same end, but results have been so meager. After three years work less than five per cent of the hospitals are institutional members of the Association. After twenty-two years of work less than one per cent of the people eligible to *active personal membership* are on our rolls.

There is no occasion for us to be proud of ourselves in any way. We cannot compare favorably with the organization of any corresponding field and are scarcely one-tenth of what we should be to pass as even a satisfactory organization.

We must recognize that hospitals are yet fundamentally local charities with a tendency toward isolation as strong as the tendency of humanity toward wickedness and we must be patient, but we believe that both the tendency toward isolation and the tendency toward wickedness alike are best checked by the development of ideals, of personal pride, and of a knowledge of good standards. All this is necessarily based on contact with each other. Somehow the Association must penetrate even the last isolation—which justifies a policy of action.

Must Use Present Opportunities

During the past year there has been ample evidence that we are generally regarded as the official organization of the hospitals and the parent of all other hospital organizations. We still have the opportunity. Will we use it, or continue to let matters drift? We must recognize that there are now clearly marked evidence that the opportunity will not be before us forever.

The dangerous possibilities from a division of the field and the development of various hospital associations representing various elements has already appeared—a vital enemy to the development of an organization large enough and strong enough to serve and to lead.

We are now seeing other organizations undertaking work we should have done. When the American College of Surgeons determined to do something to better surgical practice it was promptly recognized that certain hospital betterments were essential—so essential that the program is now referred to as the Standardization of Hospitals. We have wished them all success in their work, but we are sorry we did not clean house before others had to come in and do it for us.

One year ago the trustees of the American Medical Association seriously considered a strongly backed proposal to create a Council on Hospitals. They compromised by making the Council of Medical Education, the Council on Medical Education and Hospitals. The point of entry into hospitals by the American Medical Association is medical education and properly so, and the question is—how far will they find it necessary to go to get things

done that obviously should be done.

The moral as well as financial support generally given to the College of Surgeons should be lesson enough for the hospitals. We should by this know that there is ample financial and public support back of any sound program for the betterment of hospital service to see it through, regardless of any internal difference or opposition.

Three of our departments have organized their fields miles in advance of the hospital field—the nurses, the social workers and the dietitians—to say nothing of the medical organization or other fields reaching into the hospital from the outside.

Shall we remain content with this situation? Will we be really satisfied with all the decisions on the many important hospital questions now pending with no greater influence and no greater participation therein than we now have?

The real situation is that our opportunities have been and yet are great, while our accomplishments have been few; also that the concerted efforts of those here assembled can accomplish much in the development of the hospital field and to the credit of the Association if we all work and work together.

Definite Things the Association Can Do Now

Opinion and practice is now unified to a point that will permit the Association to formulate standards for the organization of the hospital down to and including the superintendent. The standards of staff organization as formulated by the College of Surgeons are now generally accepted and would undoubtedly be included.

The benefits to be derived by the hospital field from this are incalculable as it would determine the character of the additions to the field and gradually bring existing institutions into harmony. More questions as to hospital organizations are now coming to the Chicago office than on any other subject.

All that is required is that we be strong enough and feel ourselves strong enough to put this over, then to go at it. The strength of the organized few against the unorganized many will do the rest.

Apply Existing Standards

We can also get existing formulated standards into more general use—the standard for staff organization, for professional work, for the training of interns, for nursing education, for hospital social work, for the compilation of statistics, and others, can yet count for progress in practically all hospitals. Get all that there is in them out for your hospital.

The report of the committee studying the recording of all phases of hospital activity will be presented to this Conference in a form so that its general adoption would standardize many hospital figures and statistics. Is there any organization better qualified than ourselves to formulate these standards? Will we receive, develop, and establish this report as setting standards or will we wait until some association of accountants or statisticians writes these standards for us?

The Future

There are unlimited opportunities for constructive work and action—opportunities far beyond the capabilities of the present organization just in front of us. And we have scarcely touched the resources of the field.

The past of the Association is a fixed record, but the future will be what you make it. The next year will be practically predetermined by the attitude, the convictions and the plans of work with and for the Association which you will carry away from this Conference.

REPORT OF THE MEMBERSHIP COMMITTEE

Dr. C. W. Munger gave the report of the membership committee. This committee has considered and approved in the form all applications presented to it. The number of new members accepted in the past year and the totals representing membership in the Association are as follows:

Institutional Membership

Institutional members on roll at last Conference		310
New members since last Conference		55
One member reinstated		1
		366
Loss—Resigned	1	
—Suspended for non-payment	7	8
Total number in good standing		358

Increase for year 48, or 15 per cent.

Honorary Members

Total number of honorary members	10

No change in the past year.

Life Members

Life members on roll at last Conference	16
New members since last Conference	15
Present total	31

Increase, 93 per cent.

Active Members

Active members on roll at last Conference	875
New members since last Conference	274
	1149
Resignations	67
Number now on roll	1082

Increase for year 207, or 23 per cent.

Associate Membership

Associate members on roll at last Conference	187
New members since last Conference	32
	219
Resignations	15
Total number now on roll	204

Increase for year 17, or 19 per cent.

Total number of personal members of all classes, 1,327.

While the increase in all classes of membership during the present year has been considerable, the committee is impressed by the small portion of hospitals and hospital workers of this country who are members of this Association, and believes that a large increase in membership is vital to the Association. Each present member should feel a distinct responsibility in this matter and during the coming year undertake to secure a substantial number of new members.

ATTENDANCE MORE REPRESENTATIVE

The opinion was vouchsafed by some of the exhibitors at the Convention that the attendance this year was more representative of the best hospitals than ever before. The reason given was the fact that in the past when the conference has been held in a city local hospitals have had many in attendance, thus swelling the total. This year every one present had come expressly for the Convention.

COMMITTEE ON HOSPITAL FORMS AND RECORDS SUBMITS EPOCH-MAKING REPORT

FOR practical helpfulness to the hospitals of the country no other single item of the convention proceedings excelled the report of the committee on hospital forms and records. This committee, consisting of Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio; Dr. John F. Bresnahan, superintendent, Bridgeport Hospital, Bridgeport, Conn., and Mr. Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, Ohio, made an exhaustive study of hospital forms and record-keeping, and their report, which consisted of an attractively bound twenty-page pamphlet and examples of recommended forms, was distributed from the registration desk at the Convention. The pamphlet report of the committee contains the simple though valuable codification of all hospital activities, classified under nine general headings, with brief explanatory notes about forms used under each classification.

The report was submitted and discussed rather fully in the section on administration, held on Wednesday afternoon. At the Thursday evening meeting, therefore, its chairman, Dr. A. C. Bachmeyer, merely recommended that the report of the committee on hospital forms and records be accepted and adopted, and that the committee be continued; furthermore, that the Association express its gratitude to the non-member whose generosity made the report possible. Dr. Bachmeyer also offered the following recommendations: That the committee studying hospital forms and records enlist the cooperation of some hospital or hospital group in the report of hospital morbidity statistics, and that following Dr. Nathaniel W. Faxon's paper on "Vital Statistics that Hospitals Should Collect and Publish" the matter of considering, compiling, and recommending standard forms and tables for hospital statistics and hospital reports be referred to some existing committee or to a committee to be appointed by the Association.

Introduction to Report

Hospital statistics of all kinds do not have the same value in comparisons that statistics compiled in other fields of endeavor possess, due primarily to lack of uniformity in methods of recording. One institution cannot compare its performance or cost figures with another. This condition is objectionable and has created a demand for a more uniform method of recording all phases of hospital activity, as evidenced by the many discussions on the subject in previous conventions and by the many inquiries and appeals for assistance that constantly come to our executive office.

A generous non-member of the Association, convinced of the value of a study of the subject, agreed to bear the expense of an investigation by a special committee and the cost of publication of their report.

The committee was appointed last April. An executive secretary was employed and a questionnaire sent to about 500 representative hospitals. As a result a large volume of record forms and other data was collected. This material was then sent to each member, and formed the basis of the preliminary study. The conclusions were all formulated in subsequent meetings.

The primary purpose of the study is to establish a basis for the development of a uniform method of recording all institutional activity. This necessitates the submission of several definite formulae which must be given due attention when considering the report.

Definitions and methods of determining the number of "Hospital Days" or "Treatment Days," of computing "Average per capita per diem cost," etc., are submitted. This required a specification of the parts which shall make up the total operating cost.

The secondary purpose was to standardize practice in many details.

It is our hope that the report will serve as a guide, when new institutions are established and when changes in accounting and record keeping are made in existing hospitals.

Sincere effort has been made:

- to provide a basis for discussion of the principles involved,
- to avoid radical and untried schemes,
- to adhere to sound principles and good business practice,
- to make all procedures as simple as possible,
- to provide for elasticity, so that with little modification the recommendations will be adaptable to small or large institutions.

The committee was forcibly impressed with:

- the large number of forms used by hospitals,
- the duplication of records and consequently of effort,
- the lack of consideration of cost in composition and ruling,
- the wastage of paper stock, as evidenced by the odd sizes of forms collected,
- the disregard for standard sizes of filing devices,
- and the use of large and expensive bound books.

For these reasons, we have recommended such sizes as may readily be filed in standard filing devices and have adhered to simplicity in composition, ruling and type in the make-up of the forms.

Inasmuch as modern business practice is eliminating the bound book, we recommend the adoption of card systems and loose leaf binders wherever possible.

All institutional activity has been classified under nine general headings and the forms used under each codified in simple manner.

The report is not complete insofar as to include all types of forms now in use. Many special forms have not been mentioned.

Individual hospitals have special problems. Forms required in one institution will have no place in another.

By a Staff Photographer

The committee which drafted the epoch-making report on hospital forms and record-keeping. From left to right: Dr. John F. Bresnahan, Dr. A. C. Bachmeyer, Mr. Frank E. Chapman.

A general scheme only is submitted with the hope that, having the principles in mind, modifications or extensions will readily suggest themselves according to requirement or demand.

A report on this subject can never be final and this report will promptly bring out much discussion and constructive criticism. It is therefore recommended that the present committee be continued for the coming year and that suggestions from affiliated agencies be obtained for further study.

In preparing the report, it was necessary to call upon many institutions for assistance. The committee desires to acknowledge with sincere gratitude their cooperation, also to thank the many individuals who gave their time and effort. We further recommend that the Association extend to our generous unnamed friend, a vote of thanks, for the contribution which made the study and report possible.

REPORT ON RELATION OF HOSPITALS TO STATES AND CITIES

The report of the Committee on the Relation of Hospitals and Dispensaries to States and Cities was made by Mr. John E. Ransom, superintendent, Michael Reese Dispensary, Chicago. An inquiry into the relationships of states and cities to hospitals and dispensaries was initiated by one of the members of the Association. Because of the seeming value of the material obtained and because of the importance to the hospital world of bringing together the gist of the laws, ordinances, rules, regulations, etc., which affect the establishment and operation of hospitals and dispensaries, the trustees of the Association decided to appoint a committee to bring in a report on this subject to this meeting of the Association.

An inquiry was sent to the state board of health in each of the forty-eight commonwealths, asking these questions:

"What control, if any, does the state department of health exercise over private hospitals and dispensaries?"

"Does any other state department have control over such institutions?"

"Should the state through its regularly constituted health authority have control over medical institutions through licensing or supervision in relation to standards which might be set up by law?"

Replies were received from forty-four states. In sixteen states the state boards of health have no relationship whatever to the hospitals within those states. In other states, certain authority is exercised over certain types of hospitals but none over other types. In some states, hospitals and dispensaries are operated under state licenses and are subject to state inspection. In many states there is some regulation of hospitals through regulation of nursing education. In those states in which the requisites for licensure to practice medicine include a fifth or intern year there is developing certain control by state boards of licensure of hospitals affording intern training.

A letter of inquiry, similar in nature to that sent the state boards of health, was addressed to the municipal health department in all cities of the United States of 50,000 population or over. Replies have been received from sixty-three cities located in twenty-nine states.

Twenty city health departments replied that neither they nor any other department of the city government, exercise control of any kind over the private hospitals and dispensaries located in their respective jurisdictions. In some cities, regulation is limited to the control of contagious disease and matters of building and sanitation. Some city boards of health act as agents of the state boards of health in regard to state regulation of medical institutions. Other cities have elaborate ordinance regulating the operation of hospitals.

Summary of Findings

From the information obtained by the committee it appears that hospitals and dispensaries may have relationship to the state or municipality in which they are located through: Boards of health, boards of charity, boards of public welfare, building departments, fire prevention bureaus, factory inspection departments, boards of nursing education, and boards of medical licensure.

A detailed report giving in summary form the ways in which city and state governments exercise a degree of control or supervision over hospitals and dispensaries, is in process of preparation. Before it can be completed, however, additional data will have to be obtained from some of the cities and states under consideration. For the purpose of completing its collection of data and of placing in the hands of the Association a comprehensive report on this subject, the committee recommends its own continuance for the short period of time that will be needed.

REPORT ON FLOORINGS DELAYED

Mr. Frank E. Chapman, chairman of the special committee studying flooring materials for hospitals, reported that for unavoidable reasons the work of this committee has been delayed. A great deal of preliminary work was found to be necessary before sending out the committee's questionnaire to the hospitals. Mr. Chapman stated that in all probability the results of the study would be made public in from sixty to ninety days.

URGES MORE INTEREST IN LEGISLATION

Mr. Howell Wright, chairman of the special committee for the study of state subsidies for hospitals, made a brief, verbal report indicating that the committee had prepared a summary of literature on state subsidies for hospitals, a digest of state constitutional provision, state laws and city ordinances on this subject, and a statement of opinions of hospital officials and public officials with respect to principles and policies relating to the subsidy system. Mr. Wright concluded by urging the American Hospital Association, through its committee on legislation or otherwise, to take a more active interest in legislation pertaining to hospitals. In commenting on this report, Dr. Warner, executive secretary of the Association, conceded that the Association has been asleep so far as its legislative activities are concerned, but contended that the committee on legislation as now organized cannot do anything worth-while. To do effective work along this line the Association must begin at the very beginning, which means the creation of a section on legislation, which will undertake the codification of all laws of all the states affecting hospitals, and keep it up to date. This would mean the organization of a bureau on legislation, with a practically full-time executive head.

The Lake View Hospital of Danville, Ill., has a strong board of trustees, who believe firmly in the value of publicity for the hospital. Mr. J. W. Webster, one of the trustees, tells us that they now have two field workers, who give all their time to making personal visits on behalf of the hospital, with a view not only to raising funds, but also to getting citizens of the community acquainted with the work of the institution. The activities of the field workers are supported by a strong publicity committee of the board.

HOSPITAL LIBRARY AND SERVICE BUREAU REPORT OF FIRST YEAR'S WORK*

By DONELDA R HAMLIN, Director, Hospital Library and Service Bureau, Chicago, Ill.

THE report of the work of the Hospital Library and Service Bureau being quite lengthy, it has been printed in leaflet form, together with the outline of material being collected. Copies of the complete report may be procured from the Library. Only a summary of the report will here be given as an indication of our scope.

One hundred and seventy-eight people, representing twenty-one states, three provinces of Canada, the Philippine Islands, England, Switzerland, and Belgium have called at the Library during the past year. Many of these people have come for information on more than one occasion, so that the total number of visitors is well over two hundred and twenty-five.

Inquiries by mail have been received from thirty-five states, from Canada, South Africa, New Zealand, Malta, China, Philippine Islands, and Belgium. These inquiries have covered a wide range of subjects.

Indexing Hospital Magazines

Indexing of the three hospital magazines is well under way. A complete author, subject, and title index has been prepared for *Hospital Progress*. To date, twelve issues of *Hospital Management* and of THE MODERN HOSPITAL have been similarly indexed. That the most recent data from these journals may be immediately available, indexing has started with the current issue, working backward to the first number. As time permits, a careful analytical index will be made of articles appearing in each of these journals from the first number up to and including the current issue. These analyticals will bring out the important subject matter appearing in the paragraphs of the various articles.

Over seven hundred books and twelve hundred pamphlets on such subjects as hospital construction, administration, dispensaries, public health, hygiene and sanitation, social service, nursing, dietetics, child welfare, occupational therapy, and subjects of like nature, of interest to hospital superintendents and their department heads, have been received.

Bibliographies on thirty-two subjects have been prepared.

An exhibit similar to the one prepared for the American Hospital Association here was prepared and shown at the annual meeting of the Catholic Hospital Association of the United States and Canada.

Information as to the hospital work of architects throughout the United States and Canada has been obtained and is now available. This information is in the form of a card list which gives the name and address of the architect and a list of the hospitals he has planned. Plans of three hundred and nineteen hospitals, dispensaries, nurses' homes, sanatoriums, and allied institutions have been collected.

A number of hospital architects, accompanied by members of building committees and hospital superintendents, have met at the Library so that they might have access to material on file during their discussions.

Three local hospital associations have regularly held their monthly meetings at the Library—the Illinois Society of Occupational Therapists, the Chicago Society of Anesthetists, and the Chicago Dietetic Association.

Information has been procured from national associations dealing with the various phases of hospital and public health as to the history of their organization, purpose and scope, personnel, requirements for membership and reports and transactions. Close contact with such organizations has prevented a duplication of their work and has resulted in close cooperation with the Library.

Information is now on file as to institutions giving special courses in social service, anesthesia, public health nursing, occupational therapy, physiotherapy, laboratory technic, etc.

A complete list of the hospitals, sanatoriums, and allied institutions of the United States has been arranged by type of service so that information as to the various types is now available.

Package libraries on a variety of subjects have been prepared. These package libraries have proved to be one of the most attractive and helpful features of the work. They were intended primarily for persons in rural communities who do not have access to hospital journals, libraries, and other sources of information, but a considerable number have also been furnished to hospital workers in large cities who appreciate receiving information in so convenient a form. As an illustration of what these package libraries contain, one on the subject of community hospitals is made up of articles clipped from the various hospital journals on the preliminary organization and planning of community hospitals, articles describing general hospitals of approximately the same size as the hospital contemplated, a copy of a constitution and by-laws for a community hospital, a set of record forms suitable for a small hospital, pamphlets, reports, and other printed matter showing how other communities have organized and operated their institutions, and a reference list of such additional material in magazine or book form as cannot be sent out of the Library. This material is not sold or given away, but is loaned for a period of three weeks, at the end of which time it is returned to the Library so that it may be sent to other persons interested. Although this service was only started some three months ago, the demand for it has grown so rapidly that the material is in constant circulation.

A few words in regard to what the Hospital Library and Service Bureau is and how it functions. Both at the Library and at the Convention I have been repeatedly asked the following questions:

(1) What is the Hospital Library and Service Bureau? It is a clearing house for information on all phases of hospital construction, equipment, and administration. It serves through giving information, not advice. If the information requested is not available, every attempt is made to procure it or to refer the inquiry to the proper source.

(2) Whom does the Library serve? The Hospital Library and Service Bureau was organized for the specific purpose of serving, gratuitously, persons actually engaged in the hospital and public health field. It, so far as possible, refrains from the duplication of work of other

*Read before the semi-annual meeting of the American Conference on Hospital Service, Sept. 15, 1921, West Baden, Ind.

existing agencies. A number of people have asked if it is only the members of certain associations who have access to the Library. It should be clearly understood that anyone who is in hospital or public health work may avail himself of the services of the Library, irrespective of any connection other than hospital.

(3) With what association is it affiliated? It is under the direction and a part of the American Conference on Hospital Service. It is not directly connected with any other national organization, although, since the Conference is made up of fifteen national hospital, medical, surgical, social service, dietetic, and public health associations, it is working in very close harmony with each of these groups.

Financed by Contributions

(4) How is the Library financed? It is supported by contributions from associations and individuals interested in this work, aided by a very substantial contribution from the Rockefeller Foundation.

(5) What is the nature of the material which is being collected by the Library and how is this material available to hospital workers? The material, as indicated in the summary of the report, is in the form of books, journals, reprints, clippings, plans, specifications, record forms, reports, and material of like nature. If you will refer to the Outline of Material Being Collected you will see that this material is classified into three groups:

The material of interest to persons engaged in the preliminary work incident to the establishment of hospitals, such as financing, publicity campaigns, articles of incorporation, constitution and by-laws, methods of community organization, etc.

The second group is of service to persons who, having completed the preliminary arrangements for their hospital, know approximately what type of hospital they wish to build and what funds are available for that purpose. They are therefore interested in the construction of hospitals. The material of greatest interest to them is the material on hospitals similar in size and type to the one contemplated—material on mechanical equipment, sewage disposal, floor plans and specifications, and lists of architects.

Material Devoted to Hospital in Operation

The third group of material is devoted to the hospital after it has been constructed and is in operation. It includes material on such subjects as staff organization, by-laws, rules for interns and resident physicians, record forms, laboratory organization and equipment, charges for service, purchasing, dispensaries, accounting, etc.

As an example of the inquiries received—the superintendent of a hospital asks for information as to how other hospitals succeed in obtaining consent to perform autopsies. The superintendent of a training school asks for information as to how other schools of nursing have affiliated with universities. The dietitian perhaps wants a list of articles on basal metabolism. The laboratory technician asks for information as to where he can take a postgraduate course. The anesthetist desires information as to the laws governing the administration of anesthesia. The record keeper desires information in regard to the various medical nomenclatures. The librarian of the hospital asks for a bibliography on occupational therapy, etc., etc.

As indicated in the report, a great many of the hospitals of the United States and Canada have eagerly availed themselves of our service. Of necessity, our material and possibilities of serving develop with the increased use of the Library. It is hoped that as our work becomes more widely known all of the hospitals may realize fully the possibilities of our work and may take advantage of the vast quantity of information which is constantly being compiled for their benefit.

In conclusion I should like to say that the staff of the Library consists of six people, all of whom are working in your interests and who are both willing and eager to be of service to you.

HOSPITAL SOCIAL WORKERS HOLD SEMI-ANNUAL MEETING

The American Association of Hospital Social Workers held its semi-annual meeting in conjunction with the Annual Convention of the American Hospital Association. As there was not a quorum present at the business meeting, no vote could be taken on the proposed amendment to create sections in the Association, whereby those interested in one or another phase of hospital social service might get together for group discussions, and to study the special problems of their own work. The programs for distinct organizations during the winter and for the annual meeting in Providence in June were discussed.

Although there were not many hospital social workers at West Baden, those who were there had, besides the business meeting, an informal luncheon and a program meeting. At this second meeting interesting papers were read by Miss Alida Winkelman from the City Hospital in Indianapolis, on "The Place of the Social Worker in Determining Hospital Fees," by Miss Helen Hare of the Robert E. Long Hospital, Indianapolis, on "The Development of Local Resources by the Hospital Social Workers." Miss Mary B. Combs, of Brooklyn, brought with her a paper on the work of the Health Clinic at Mount Sinai Hospital, New York, showing the value of group instruction, class work methods, and the participation of the social worker in such clinics. The paper was written by Miss Alice Holcomb and Miss Jean Aldrich.

The discussion of these papers was lively and helpful. Everyone was interested in comparing experiences, questioning methods, and stimulated to a resolve to study some particular phase of her job. Miss Cannon, the president, presided at all of the meetings, and in closing the special program meeting urged the members "to make a hobby" of some part of their work—to become specialists on some aspect of their everyday problems.

This eagerness to study was generated by admiration of Miss Thornton, whose paper read at the section meeting on social service, "The Place of Social Service in the Administration of Hospitals and Dispensaries, or the Relationship of Hospital Social Service to Other Hospital Services," is a most valuable, thoughtful analysis of the activities of a medical institution and is based on Miss Thornton's own experience and study.

The annual meeting of the Association will be held in Providence, in June.

CANADIAN HOSPITALS RESPONDING

Dr. MacEachern, superintendent of Vancouver General Hospital, Vancouver, B. C., is elated over the way in which Canadian hospitals are responding to the standardization program. His associate, Dr. T. R. Ponton, has just completed a transcontinental tour, in which he visited practically all of the hospitals of fifty beds and over in the interests of the standardization movement. Already about 62 per cent of the hospitals of 100 beds and over have adopted the minimum standards promulgated by the American College of Surgeons.

1921 EXPOSITION SURPASSES PREVIOUS YEARS

A BACKGROUND of massive columns touched with the rich colorings of Pompeian decorations—a circular spread of mosaic floor, ten score feet across—far above, a translucent dome crossed with a spider web of steel—ferns, palms, statuary—the creamy white and green of the many arborlike booths blending into the picture—such is the memory of the 1921 hospital exposition.

Surpassing in size and value, and excelling in beauty all previous exhibits, the 1921 exposition must be regarded as a marked accomplishment on the part of the American Hospital Association. Not only were there a greater number of individual exhibitors, but each exhibit offered more of educational value to visiting superintendents.

One could not but be impressed with the importance of the commercial elements represented, of the distinct service these firms have rendered and are rendering in the development of the hospital field. The research of commercial experts, the development of new methods and equipment, the cooperation and energy expended in promoting educational exhibits—all have contributed in generous measure to hospital progress. The number and extent of the exhibits at West Baden gave a striking example of the interest business firms feel in the hospital field.

By a Staff Photographer.

The exposition of equipment and supplies, looking toward the exit to the golf links.

The cooperation of various business firms was evidenced particularly by the nature of their exhibits. The Association had urged that the 1921 exposition be designed along educational lines. As a result, practically every booth was planned so as to give the maximum of information to the hospital executive. Methods of manufacture, comparative qualities, range of grades, the application of products to hospital use were displayed and demonstrated. Order books were discarded for the Convention and salesmen became for the time being instructors, anxious to explain the value of their appliance and its usefulness in the hospital. Naturally, orders proffered were not refused, but there was less intensive selling effort at West Baden than at any previous convention.

The educational value of an exposition thus planned is obviously great. In no other way is a hospital superintendent able to inspect, examine and compare such a wide range of products used in his institution. A study of the commercial exposition as constituted at West Baden and as planned for future years offers in reality a liberal education in hospital purchasing.

Range of Exhibits

Practically every commodity used in an established hospital was shown at the West Baden exposition. Every department of an institution was represented, although display exhibits of kitchen and kindred lines were not made as fully and completely as those of clinical supplies and equipment. Nevertheless, the range of products shown was so complete that a new hospital would have been able to purchase a large part of the equipment and supplies that would be needed without leaving the exposition.

Probably half of the exposition was devoted to clinical supplies and equipment, and the exhibits of the various concerns were most complete. Hospital furniture was shown in great range and variety, both in the standard white enamel and in the new finishes which are favored by many superintendents. Surgical instruments of every kind were on hand. The leading makes of pressure sterilizers offered instructive exhibits as well as sterilizer controls. Surgical supplies, the articles which must be bought most frequently in the clinical department of the hospital, were shown in profusion and included rubber goods, enamel ware, cotton, gauze and surgical dressings, as well as ligatures and sutures. Various specialty houses demonstrated the value of their products, including electrically lighted instruments, metal hot water bottles, surgeons' gloves, rubber sheeting straps, radium applicators, paper goods, extension splints, blood pressure equipment, identification necklaces and other similar specialties. Apparatus for anesthesia was shown and demonstrated in two commercial booths

Pharmaceutical and allied products were not largely exhibited. There was one booth showing certain specialties such as glandular derivatives, another booth offered alcohol, while other booths offered disinfectants and allied chemicals. There was also a limited display of electrotherapeutic and x-ray equipment. Therapeutic lamps and thermo-electric applicators were demonstrated in two exhibits. The failure to receive a freight shipment prevented the exhibit of x-ray units and allied apparatus.

Closely allied with general clinical products are hospital garments, and these were on exhibit in a number of booths, permitting a close comparison on the part of the buyer. The superintendent interested in pathological laboratory equipment had available a large exhibit devoted solely to such equipment and supplies, while additional laboratory supplies were shown by several other concerns.

Ambulances Demonstrated

For the first time in the history of the commercial exhibit, hospital superintendents had an opportunity to inspect ambulances. Three different makes were shown, one on the floor of the exposition hall, while two were demonstrated on driveways adjacent to the hotel. Considerable interest was aroused in these exhibits, apparently many superintendents being in the market for ambulance equipment.

The importance of textiles in the hospital purchasing budget was evidenced by the number and variety of such exhibits. A wide range of styles and quality in bed and table linens, blankets, comforters, towels, as well as

various piece goods were shown and the various booths were well patronized at all hours.

Considerable interest was aroused in record and record systems as a result of the report by the special committee on hospital records and forms. In one of the largest booths various filing equipment was shown and a demonstration was also made of the various forms recommended by the special committee and approved by the Association. Various record forms were also demonstrated in connection with other exhibits.

There were two complete exhibits of hospital beds, permitting the inspection of a considerable variety of beds, suitable for general as well as special purposes.

Foodstuffs in Limited Display

There was not a great range of foodstuffs shown at the exposition. The two exhibits were devoted primarily to canned fruits and vegetables, in one of which was an interesting display of the various grades, according to the classifications recommended by the Association. There were also two displays of desserts and one of malted milk. One booth was devoted primarily to infant foods.

A considerable number of exhibits, however, were devoted to food service equipment, although there was no exhibit displaying a complete range of kitchen and allied equipment. In one booth various items of kitchen equipment were shown by illuminated photographs; in another aluminum utensils and aluminum jacketed kettles were displayed. Mixing machines for general kitchen and bakery use were demonstrated in actual operation in three exhibits. Insulated food conveyors at two booths aroused considerable interest among superintendents. Dish washing equipment in actual operation was displayed by two firms. Milk and cream dispensing urns and ice chippers were kitchen specialties displayed, while interesting demonstrations were given of automatic electric toasters in various sizes.

Hospital superintendents attending the exposition had an unusual opportunity to study the necessary equipment for hydrotherapeutic departments as well as plumbing equipment specially designed for hospital use. Two of the largest exhibits were devoted to such apparatus, in one hydrotherapeutic equipment being in actual operation and demonstrated by a trained attendant. Sanitary toilet seats and water mixing valves were also shown.

Only a single exhibit was devoted to laundry machinery, but here the superintendent could study the latest types,

By a Staff Photographer.

The exposition of equipment and supplies, looking toward the exit to the mineral springs.

By a Staff Photographer.

The exposition of equipment and supplies, looking toward the dining room and mineral baths.

including a silver burnishing machine. In another booth a laundry marker and marking inks were demonstrated, while laundry soaps and cleaners were carefully explained by one of the leading firms in this line. Trucks for the laundry were shown in various styles and sizes.

Building Specialties

There were a number of interesting exhibits of building specialties and these attracted considerable attention among visitors. In one, metal weather strips and window shades were shown and explained. In another a miniature nurses' call system was shown in operation. A specially designed hospital window was featured in a special booth and attracted considerable attention. The value of rubber flooring and treads was interestingly demonstrated. Laundry chutes and window ventilators were among other building specialties shown. An exhibit of window screens and awnings was unavoidably detained and was missed by convention visitors.

Several exhibits were devoted to brushes, mops and similar janitor supplies. An interesting display of wheel chairs, trucks and casters attracted considerable attention. The importance of a proper dentrifice was convincingly explained in one display, while shoes for nurses as well as patients were generously exhibited in another. The display of books by two well known publishing houses specialized particularly in nursing and allied subjects. One of the publishers also displayed anatomical charts, while an interesting exhibit was made by a firm specializing in anatomical models and charts.

A complete list of exhibitors, with the names of those in charge and the products displayed, was given in the September issue of THE MODERN HOSPITAL and also in the Convention Supplement distributed at the meeting.

HEARD AT THE CONVENTION

"Oh, you are from Jefferson County Hospital, where they do so much for the patients." This chance remark, overheard at the Convention, seems to show that satisfied patients have a way of boosting a hospital that no amount of newspaper publicity can accomplish.

The county hospital idea is growing apace in Illinois. In addition to the Jefferson and Washington county hospitals, Henry county now has a twenty-five-bed hospital at Mount Pleasant. Boone county has taken over the Eleanor Moore Hospital as a county institution, and Mahaska has a county hospital at Haskaboose.

THE HOSPITAL EXPOSITION—AN APPRECIATION AND A CRITICISM

By the Superintendent of a Hundred Bed Hospital

EDITOR'S NOTE.—The hospital superintendent who writes this report was requested to make a critical survey of the exposition, with a view to submitting recommendations for the benefit of the entire hospital field.

I AM the superintendent of a medium sized institution. I am not a doctor; I am a business man and am trying to run my hospital along business lines. The purely clinical care of patients, while undoubtedly important, is but a part of the complete, well-rounded service that our hospital seeks to give. Then, too, I am interested in the profit and loss account at the end of the year and it is in the general administration of the hospital that the money is lost or saved rather than in the purely clinical side.

I came to the Convention with the keenest interest and expectations.

I left the Convention with mingled feelings in which disappointment predominated.

When I say I was disappointed with the exposition, I am giving a negative reason. My disappointment arose more because of what was not exhibited than what was.

Recently, because of my interest in what might be called the domestic side of the hospital, I visited the annual Hotel Exposition. The contrast between this exhibit and the hospital exposition was most striking. At the Hotel Exposition kitchen and food service equipment were shown in actual operation. The interested buyer could see ideal layouts, could select if necessary the complete equipment of a kitchen. The same applied to the laundry and other domestic departments which are similar in both hotels and hospitals.

By a Staff Photographer.

A view of the exposition of equipment and supplies, taken from the balcony above the registration desk.

But let me be more specific. About one-third of the hospital dollar is spent for food. I found at the Convention only four exhibits that could be classed under the general heading of foods. Two of these were desserts, the other two primarily canned fruits and vegetables. The total extent of the products shown represented but a small part of the hospital dollar. Where were the meats, the staple foods? Are there no national concerns selling staple or general food products to the hospital trade?

Following foods, one naturally thinks of food service equipment. The Convention this year was singularly lacking in exhibits of general kitchen equipment. True, there were exhibits of food carts, utensils, aluminum kettles, toasters, milk dispensers, etc., and one concern had illuminated pictures of general equipment.

Hoped to See Model Kitchen

I do not go to conventions to buy, but rather to be introduced to new ideas, to learn how to better the equipment and service of my hospital. I had hoped that I could see a model kitchen; model in arrangement, model in equipment. Possibly I was expecting too much, but it does seem that if a single manufacturer was not able to present an exhibit of this kind that the Association could have arranged for a complete kitchen exhibit, comprising the products of several concerns.

The venereal disease clinic showed a model office outfit; would it be much more difficult to show a model kitchen with its equipment?

The same applies to laundry equipment. There was a well arranged exhibit by one concern, yet it would seem much more desirable if it had been possible to present a complete, ideally arranged laundry for the moderate sized institution.

Here again we have a parallel. There were two very complete exhibits of hydrotherapeutic apparatus—one in actual operation. It would have been no more difficult to have shown a complete laundry outfit, in miniature if not in actual working size.

The same criticism applies to the lack of other products. I had hoped to see more of general equipment such as refrigerating equipment, floor scrubbing machines, vacuum cleaners, and similar appliances. I would have been much interested in an exhibit of paints which emphasized the practicability of different paints for different hospital uses.

The Association at the present time is making a study of flooring materials. Yet, with the exception of one rubber flooring material, no information was available at the exposition, although the time for such a demonstration was undoubtedly ripe in view of the committee's work on this problem.

The purchase of wood furniture has always been a source of trouble. I fully expected to find some manufacturer showing various pieces of wood furniture most largely used in the hospital. I wanted to see dressers; I was anxious to find rockers for private rooms with a form fitting back, high enough to rest the patient's head.

These are but a few of the shortcomings of the 1921 exposition.

In my opinion, too many of us are so prone to regard the hospital solely from the clinical angle that we overlook and neglect many of the general problems of the hospital which are responsible for the major portion of our expenditures, and for much of the satisfaction and dissatisfaction of our patients.

The representative of a firm handling kitchen equipment told me of his experience. One morning four superintendents (all doctors) hesitated at his booth. All expressed indifference to the subject of kitchen equipment, saying that such matters were left to the steward, the

By a Staff Photographer.
The exposition of equipment and supplies, looking toward the hotel lobby.

dietitian, or the cook. One in fact, when asked regarding the steam table in his institution, expressed complete ignorance of the kind, size, or nature of the steam table used in his kitchen. I firmly believe that so long as superintendents continue to ignore important problems in the conduct of their institution, just so long will our hospital expositions be out of balance, and just so long will many hospital statements show in red at the end of the fiscal year.

As I said before, I came to the Convention, not to buy, but to benefit by a study of the exhibits, and through attendance at the meetings. I found, however, that if I conscientiously attended the various sessions in which I was interested, I would have but little time to view the exhibits. I believe this was a predicament in which many visitors found themselves. I very much desired to visit every booth in the rotunda, but it became a physical impossibility. As a suggestion to those in charge of the 1922 convention, it might be well to so arrange the program as to permit convention visitors to spend greater time in the exhibits. Possibly half of one day might be devoted to this purpose, or at least the noon intermission could be lengthened so that each day for a certain period there would be time to visit the various booths and confer with the experts present.

Disappointed at List of Experts

Speaking of experts, I could not help feeling disappointed with the list of official experts as announced. The range of subjects covered by these men was limited, and it is indeed a question if there were not other men attending the Convention equally qualified to give expert advice on the subjects selected as well as on many additional topics.

I have been purchasing equipment and supplies for my institution for many years, and I am frank to say that I have found but few salesmen that have not been able to help me and throw new light on those products in which they specialize.

I often wonder if other superintendents place the same value upon the commercial exhibits that I do. To me a study of the exposition means more than the convention sessions. Convention discussions and papers are reprinted in the various hospital publications and in the official transactions of the Association, and can be studied and digested after my return home, while the full benefit of the commercial exposition can only be gained by a study of each individual exhibit and contact with the representatives of the various firms. I cannot help feeling that the commercial exhibits offer opportunity for a liberal education in the purchasing of the equipment and supplies for my hospital.

Probably every one that goes to the Convention has a different method of studying the commercial exhibits. To me the exposition as arranged was confusing, and I feel that it would have been much easier for all of us superintendents if exhibits had been grouped according to some classification so that one section of the hall could have been devoted to purely surgical supplies, another to food products, another to textiles and so on. Possibly this might have led to undesirable rivalry between competing exhibitors, and yet such an arragnement would greatly simplify the efforts of the man who came to the Convention determined to study and possibly purchase certain particular products.

Exhibitors Let Opportunities Slip

Have you ever noticed how many exhibitors—you might say the majority of them—seem to travel in a rut? Each year they exhibit practically the same products in practically the same manner. Frequently opportunities are overlooked; they do not take advantage of the annual exposition to present new ideas. For instance one of the items in my "want list" was an autopsy set. The Association has laid great emphasis upon the desirability of holding more autopsies, and I had decided to purchase an outfit for this purpose. Imagine my surprise after making the rounds of the various surgical exhibits not to find a single autopsy set. The same difficulty arose in selecting equipment for my venereal disease clinic. None of the instrument manufacturers were able to offer a convenient and compact set of instruments for the purpose, although several stated they had special furniture for such a clinic.

Although I was disappointed because many products were not exhibited, I was really surprised and amazed at the size and extent of the 1921 exhibit.

Not only were there more exhibits than in past years, but the beauty of the entire exposition has never been equalled. The great rotunda furnished an ideal setting, enabling the different firms to present their products in a most effective manner.

Clinical Supplies Well Represented

As I said before the exhibits of clinical supplies and equipment predominated and these were exceptionally complete. Instruments and surgical supplies, rubber goods and surgical dressings were shown in great variety. Leading makes of sterilizers were on exhibit, steel hospital furniture of every description was shown. Several of the manufacturers presented an interesting change from the stereotyped white enameled furniture by offering certain equipment in standard wood finishes and in grey and other colored enamels. This seemed to me a most sensible advance, which will tend to take away the "horror" from much hospital equipment, and remove the glare that is always present with all-white furniture. Many interesting specialties were shown, such as electrically lighted instruments, radium applicators, and many convenient labor-saving devices that should have a place in every institution. Hospital plumbing received splendid attention, the exhibits being especially complete. One of the exhibits had a complete hydrotherapeutic outfit in actual operation and an attendant present described the technique of hydrotherapeutic treatments to all interested.

I was very much interested in the exhibits of hospital records and record keeping methods, particularly in view of the complete report presented by the special committee

studying the subject. This report extended beyond merely clinical records and discussed in a comprehensive manner record forms for the administrative and other departments. Frankly, it has always seemed to me that these departments had been neglected and the standardization of forms for general use throughout the hospital should do much to improve general hospital administration. Particularly is this true when it is possible to secure not only record forms, but proper filing systems and equipment from the same concern.

That various textiles form an important part in hospital purchases was evidenced by the numerous complete exhibits at this Convention. The various booths presented a wide variety of bed and table linens, towels, blankets, spreads, etc. The wide range of quality of such merchandise is very apt to prove confusing to the inexperienced buyer. Standardization of textiles would seem to be a logical and important subject for intensive study by the Association. While such standardization would possibly work hardships on individual dealers, the benefit to hospitals would be great.

Should Standardize Garments

The same applies in a considerable degree to hospital garments. The selection of certain standardized weights and counts for various purposes would simplify purchasing to a marked degree. The exhibits of hospital garments at this Convention were complete, but here again the wide range of quality in material tended to confuse the purchaser.

Although the number of food exhibits was limited, the showing of various grades of canned fruits and vegetables by one exhibitor, classified according to the standards recommended by the Association, was most interesting and valuable. The tendency in the past has been for canners and dealers to show only their best grades, for many uses the cheaper grades are equally desirable and offer means of possible economy to every hospital.

For the first time, I believe, in the history of the Association, various makes of ambulances were exhibited, one being placed within the rotunda, while two others were demostrated on the driveways and approaches to the hotel. Considerable interest was shown in this important part of hospital equipment and this innovation in the exposition was well warranted.

The so-called non-commercial exhibits came in for a generous share of attention. The Hospital Library and Service Bureau, particularly, proved a magnet for many hospital architects and executives. The completeness of the data gathered by this new organization was surprising and gave proof of the increasing value to the field which the Library will offer.

The exhibit of out-patient work, including a model venereal disease clinic, was very complete, but for some reason did not seem to arouse the interest among visitors that was noticed in previous years. Possibly this was due to an unfavorable location.

The impressions I have offered may appear as severe criticism. My purpose, however, is purely constructive, with the hope that the suggestions offered will enable future expositions to more nearly approach the ideal desired by progressive hospital executives.

PUBLIC HEALTH SERVICE WILL RETURN TO PRE-WAR ACTIVITIES

"Glad as the Public Health Service has been," says Surgeon-General H. S. Cumming, "to do its part in the hospitalization and care of the ill and disabled soldiers with whom its officers had become so well acquainted while serving in the army hospitals in France and elsewhere, this duty did not constitute a part of the Public Health functions of the service but was undertaken through patriotism and because the service was the only government agency that had an organization and hospitals available when the need came. Later its assignment to this duty was made a matter of law.

"From March 3, 1919, when this law went into effect, to May, 1921, when the hospitalization and care of nearly half of these patients was transferred to the War Risk Bureau, the number of former military patients in the charge of the Service increased from 990 to 25,000, with indications of still further increase. From the first the number had increased much faster than the total capacity of the government hospitals could be extended; and almost from the first the Service was compelled to place about two-thirds of its patients (10,500 on May 1, 1921) in private hospitals under contract.

"Responsibility for these 10,500 patients has already been restored to the War Risk Bureau; and, if bills pending before Congress become law, the hospitalization of the patients cared for in government hospitals as well as in 'contract' hospitals will rest with the War Risk; and the Public Health Service will merely render hospital care to those whom the War Risk assigns to it.

"This will enable the Service to turn a much larger share of its energies to its traditional duty of protecting the country against the importation of foreign disease; conducting scientific research into important problems involving the cause, treatment, and cure of preventable or communicable disease; investigating the diseases to which workingmen are subject by reason of their employment; cooperating with the states in the control of epidemics in rural hygiene, child hygiene, venereal disease, and so on."

COMPLETE GEOGRAPHICAL REGISTRATION

State	Personal Members	Institutional Delegates	Guests
Alabama	2	1	..
Arkansas	1	1	..
California	2	..	..
Colorado	2	1	..
Connecticut	4	1	..
District of Columbia	1	..	..
Delaware	1	..	..
Florida	2	1	..
Georgia	1	1	..
Idaho	1	..	..
Illinois	39	12	20
Indiana	21	3	16
Iowa	5	7	1
Kansas	1	2	..
Kentucky	1	3	6
Louisiana	2	2	..
Maine	1	1	..
Maryland	5	2	1
Massachusetts	11	5	1
Michigan	21	12	5
Minnesota	11	2	2
Mississippi	1	..	..
Missouri	13	8	1
Nebraska	3	3	1
New Jersey	7	2	1
New York	45	15	9
North Carolina	5	1	..
North Dakota	1	..	..
Ohio	38	29	16
Oklahoma	2	..	..
Oregon	2	1	..
Pennsylvania	36	21	8
Rhode Island	3	..	..
South Carolina	2	..	..
South Dakota	2	1	..
Tennessee	3	1	3
Texas	2	8	1
Utah	1	..	..
Vermont	2	..	..
Virginia	1	1	..
Washington	2	..	..
West Virginia	1	1	..
Wisconsin	9	5	3
Canada	12	2	..
Foreign	..	..	..
China	..	..	1
Total	328	156	96
1920 conference:			
Montreal	271	155	439

PROTESTANT HOSPITAL ASSOCIATION HAS TWO ACTIVE SESSIONS

AT THE Protestant Hospital Association meeting, held at West Baden, September 12, 1921, at 1:30 p. m., the president, Mr. Pliny O. Clark, superintendent of the Presbyterian Hospital of Denver, Colo., spoke on the unlimited possibilities for service before the Association. He said that the Association wished to emulate the American Hospital Association and the Catholic Hospital Association in their programs, and to cooperate with them whenever possible. He spoke on the duty of the superintendent to get the entire community behind the hospital, for should not the entire community support their hospital just as they do their fire department, not leaving it to those who happen to need its services? He ended by quoting from Ruskin the words which he wished to apply to the work of the Association, "When we build let us think that we build forever."

Then followed the report of the executive secretary, Rev. Frank C. English, Cleveland, Ohio. This report, as he pointed out, was different from most, in that it told of the beginning of the Association, and covered the first two years of its existence. The Association was organized in September, 1919, in Cincinnati at a meeting called by Dr. English. Here superintendents talked over hospital programs, pointing out that church hospitals had problems which they could better solve if they were banded together. Dr. English was elected first president of the Association. In May, 1920, the organization was completed. Several service bureaus were formed, among them the bureau of information, one on architecture and supplies, and one on intern and nursing service.

We have now come to the period of organization, to the time when we live not unto ourselves alone, each hospital with its own problems which do not concern or have any duplication in sister institutions; rather we see that the problems of one are the problems of all, that the solution of one has an application in nearly all other like situations, that the field is white unto the harvest, and that we must plan unitedly if we are at all adequately to cover the field.

An eminent minister recently said: "The Christian religion has three fundamental purposes, teaching, preaching, healing," and coordinated the last with the other two in strength and effectiveness.

If such is truly the case, should we not more courageously attack the problems of health before us each day?

PLINY O. CLARK, President,
Protestant Hospital Association.

In Montreal, October 7, 1920, there was a meeting at which it was voted to support the American Hospital Association, and become one of its sections if that were desirable, and the advantages of a church hospital association were talked over. The idea was reindorsed and the association was voted. Since that time committees have been appointed which have not yet met, and the work has been done by the president and the secretary. Four sets of letters have been sent out, and a set of questionnaires. Answers to the questionnaires showed that the Protestant hospital executives believed the Association to be justified. Some of the letters formulated the ideals of the convention as the effort to gather together such suggestions that the ideal Protestant hospital might be visualized.

Following the secretary's report the president appointed several committees—a church cooperation committee, a resolutions committee to pass on various resolutions which had been prepared by members of the Association, and the committee on nominations.

The discussion on practical problems brought out many ideas of interest. Mr. Joseph Purvis, superintendent, Memphis General Hospital, Memphis, Tenn., spoke on "The Hospital Executive—His Problems, and Some of His Duties, and the Selection of Trustees." The problems of the superintendent are extremely varied. One department of the hospital often infringes upon another, and the resulting problems are brought to the superintendent. A staff which is well organized is the first step towards solving the superintendent's problems. It is often difficult to get the trustees to cooperate, and this constitutes another problem for the superintendent to solve. Still another is the change in the nursing situation brought about by the shorter hours, and the shortage of pupil nurses. There is hope of an early adjustment of this, however.

The duties of the superintendent are numerous and varied. Mr. Purvis feels that the superintendent should be both born and made. He is the creative power behind the machinery, and his product is thought. The measure of his work is not in exterior things, and he should spend the minimum amount of time in routine work. Organization, cooperation, service and efficiency are the dominating things in the hospital, as in any business enterprise.

The selection of trustees is a baffling problem. Many men will accept the position as a compliment, not intending to do any productive work. Sometimes a member is chosen for business, social, or financial reasons. He is of no use to the hospital. All he does is to answer the roll call, and ask how things are going. Members of the board should be willing to do any service, have sympathy for the sick, and count it a privilege to serve in this way. They should be chosen for ability, and they should familiarize themselves with every department of hospital work. A close relation between the staff and trustees and the executive is absolutely essential. The board should be consulted concerning buying and repairs, and it should hold informal meetings with the staff. It should be divided into several committees, for instance, house and grounds, finance, social, religious. It should meet at least once a month. The trustees should endeavor to get the entire community behind the hospital. Churches and schools are supported by the public, why should not the equally important institution of the hospital be so supported?

A discussion of Mr. Purvis' paper was given by Dr. James R. Alexander, secretary, Presbyterian Hospital, Charlotte, N. C., who agreed that the executive's main contribution was thought, which was shown in the work of his subordinates. The executive should not be

a dictator, but allow the head of each department to develop it as he sees fit. A general discussion followed, in which there was unanimous consent that superintendents should attend the meetings of the board of trustees, that they should have the entire confidence of their board, and be allowed sufficient latitude to work out their own salvation.

Mrs. Ethel P. Clarke, director, school of nursing, University of Indiana, read an excellent paper on "Schools of Nursing as Educational Institutions." The apprenticeship system which began in the first nursing school in St. Thomas' Hospital, London, still persists today, and it must be stamped out. It keeps the pupils from receiving a broader education. On the whole, however, the schools do give their pupils a fine education, and send them out to serve the sick, both in hospitals and in communities. There is an ever broadening field for the nurse in public health work, and in hospitals.

Definite Standards Demanded from Schools

Mrs. Clarke advocated the charge of a tuition fee by the nursing schools, on the principle that they would then take their place more quickly among other educational institutions. She advocated affiliation with universities, and the graduating of students at regular times during the year, so that better planned courses of study might result. Rather than shorten the nursing course, the third year should be enriched. The war gave publicity to schools, some of it desirable, and some otherwise, but it served to make definite standards known. The student of today knows what she wants, and it is the duty of the hospital to give it to her. Miss Sara E. Parsons, St. Louis, Mo., sent a paper to be read during the discussion of this question, in which she advocated the formation of a training school committee, with one educator, two or three training school executives, the superintendent of a hospital, and the superintendent of a school. This committee should visit other schools and keep itself informed on nursing problems. In the general discussion the point was brought out that public opinion should be made less sentimental concerning student nurses. They should be no more pitied than students in our colleges. They are intelligent women, seeking an education.

Patients Should Pay for Service

Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, talked on the financial problems of church hospitals. Hospitals should supply the best laboratory equipment and the most competent personnel obtainable, but patients should be made to pay for this service. Things worth having are worth paying for. Careful accounts should be kept of the hospital, and the well-to-do should pay the full cost of their maintenance. As for buying in the hospital, it is better to have the superintendent know what not to buy than what to buy. Things which litter the basements and storerooms of hospitals, and food which the patients do not like are some of the things not to buy. If the superintendent wishes his staff to boost the hospital, he should treat them according to the golden rule, do as he would be done by. He should know them, their hopes and ambitions; he will find they will respond by giving more to him than he could possibly give to them. He should also pay them good salaries.

After a short discussion on the community chest, which was entirely approved by two superintendents whose hospitals participated in this system, the meeting closed with the report of committees.

At the evening meeting of the Association a round table was conducted by Dr. Frank Clare English, St Luke's Hospital, Cleveland, in the convention hall, the general topic being "How Can the Protestant Hospital Association Best Function?" A number of pertinent questions were placed in the question box; the following are illustrations: "How may we secure the support of the public?" One woman declared that if the "woman fad" were promoted, women could secure a larger publicity and consequently a larger response than by any other method. "How may we secure financial support for our hospitals?" "How may we obtain the best professional services?" "How can we get all of the churches interested in our hospitals?" "What constitutes the ideal Christian hospital?" Answering this last question, it was thought the managers of the hospital should acquire enough knowledge about hospital government methods, personnel, organization, patronage, gifts, handling of finances and supplies, to be able to devise an ideal institution. One leading question was, "What will produce the spirit of service versus the commercial spirit?" This was discussed with great enthusiasm, as it was thought one of the prime reasons why there should be a church hospital association. There were several questions on hospital ethics; also on handling financial campaigns. Services for crippled children, and the sick living in remote places were thought imperative. It was stated that there are more than fifty millions of people living outside the great centers, for whom very little hospital service is offered. It was urged that the 171,000 Christian ministers should become active agents of the hospital, to bring to the neglected sick proper hospital care.

Church Mission Hospitals Need Nurses

Following the round table there were two addresses. "The Call for Nurses for Home and Foreign Mission Hospitals" was presented by Miss Alice Thatcher, superintendent, Christ Hospital, Cincinnati. Miss Thatcher's paper was well prepared, carefully elucidating the subject. It was made clear that there is an open door for the ministry of nursing in church mission hospitals, but that too often the door is left open with no one entering.

Rev. Dr. J. E. Lacont, of New England Deaconess Hospital, Boston, gave a stirring address on "The Call of Humanity." He clearly defined the place of the Christian hospital in developing men and women for a definite life service.

Officers Elected

The following officers were elected for the coming year: president, Pliny O. Clark, superintendent, Presbyterian Hospital, Denver, Colo.; vice-president, Dr. Charles S. Woods, superintendent, Methodist Episcopal Hospital, Indianapolis, Ind.; general secretary-treasurer, Dr. Frank C. English, St. Luke's Hospital, Cleveland, Ohio.

HOSPITAL ADOPTS RESOLUTION IN FAVOR OF AUTOPSIES

The board of directors of the Beth Israel Hospital, New York City, at its meeting of February, 1920, adopted a resolution concerning autopsies, to the effect that "Autopsies, having been found by the progress in medical science seemingly essential in many cases, shall be performed upon bodies of the Jewish dead, if the same can be done in conformity with Jewish rights, laws, and customs, and that the necessary propaganda be made, appropriate for the purpose." Pursuant to the above resolution a campaign has been started to induce the rabbis to recognize the need that ante-mortem symptoms be correlated with post-mortem findings so that the art of diagnosis, and in this way the art of healing, may be advanced.

AMERICAN DIETETIC ASSOCIATION TO HOLD ANNUAL MEETING IN CHICAGO

THE fourth annual meeting of the American Dietetic Association will be held in Chicago, October 24, 25, and 26, at the Hotel La Salle. All the meetings will be held in the convention hall on the nineteenth floor, exhibits, both commercial and non-commercial, being in the ball room on the same floor. In the reception hall connecting the two rooms the registration and information desks will be found. This arrangement is most satisfactory, as everything will be accessible and convenient for members. The officers are:

Miss Lulu G. Graves, honorary president, superintendent, dietary department, at Mount Sinai Hospital, New York City; Mrs. Mary DeGarmo Bryan, president, 626 Bergen Ave., Jersey City, N. J.; Dr. Ruth Wheeler, first vice-president, professor of nutrition, University of Iowa Medical School, Iowa City, Iowa; Miss Rena Eckman, second vice-president, house director, University of Michigan Hospital, Ann Arbor, Mich.; Miss E. M. Geraghty, secretary, student, University of Illinois; Miss Ellen Gladwin, treasurer, head dietitian, Jefferson Hospital, Philadelphia, Pa.

Other members of the executive committee are:

Miss Mary Lindsley, manager, Grace Dodge Hotel, Washington, D. C., and Miss Lucy Gillette, head of nutrition bureau, A. I. C. P., New York City.

When considering whether or not you will attend the A. D. A. meeting in Chicago, glance over the following and see if you can afford to miss it.

The wide scope of the program makes it one of great value to dietitians in all phases of the work. Many speakers are people who have written the articles which you read in professional and scientific magazines. Do you realize that after hearing a writer speak of his work, you get more out of his articles because you then unconsciously read his personality into them?

The round table discussions are to be numerous and very informal—every dietitian will have an opportunity to discuss her problems. No one should leave the meeting with any question unanswered, or at least satisfactorily discussed.

The commercial exhibit will be especially good this year, as equipment and labor saving devices are to be emphasized. This will give you who are planning new kitchens or dining rooms an opportunity to see all types of equipment and to decide which is best for your needs. The non-commercial exhibit is to consist of charts, bulletins, health posters, and all forms used in the business management of dietary departments.

Your association with professional and commercial people will be as valuable as the round table discussions because of the very personal contact.

Many important institutions are welcoming our members. The Chicago association is planning a series of trips through these institutions on Thursday, October 27.

Remember Chicago's unlimited resources for entertainment, with its park system, 180 miles of parkway and boulevard; forest preserves, 20,000 acres; public buildings, libraries, the Art Institute, Field Museum, etc.; motor trips about city; settlement houses; theaters and recreation centers; and union stockyards.

Transportation

A reduction to one and one-half fare on a round trip ticket on the certificate plan will be given to all members attending the meeting, this arrangement applying from the following territories: Central Passenger Association Territory, Western Passenger Association Territory, Southwestern Passenger Association Territory, New England Passenger Association, Canadian Passenger Association Territory. For details write.

A number of hotels are most desirably situated in the central part of the city. They are convenient to most of the railroad stations, the shopping district, and many points of interest. Rates for the Hotel La Salle and other hotels may be found in THE MODERN HOSPITAL for September, 1921.

The Hotel LaSalle, headquarters of the convention of the American Dietetic Association.

Situated as it is on the corner of Madison and La Salle, street cars going to all parts of the city may be taken at the door. The elevated is only one block away. A list of points of interest will be furnished at information desk.

The hotel possesses a peculiar distinctive charm which is apparent from the moment you enter its doors. It is the only hotel in Chicago giving the comfort and convenience of individual clerk service on every floor.

For the woman who travels alone the hotel offers the personal attention of a maid who shows her to her room, and is at her command to insure privacy and homelike comfort. Here, in a hotel which is situated so as to give a guest the advantage of easy access to shops, theaters, and all the city's interests, there is an atmosphere of hospitality which appeals to those who want the comforts of home and the formalities of hotel life.

The popularity of the restaurants is due to the high quality of food served, the care taken by skilled chefs in its preparation, and the quiet, efficient service in the dining combined with the attractive feature that the prices are very reasonable. The Blue Fountain Room, one of Chicago's most popular restaurants is open for

LULU G. GRAVES
Honorary President, American Dietetic Association
Superintendent, Dietary Department, Mount Sinai Hospital, New York

luncheon, dinner, and supper daily. Service is strictly à la carte. Here you will find good music, courteous service, and cheerful surroundings.

Headquarters and Exhibits

The Hotel La Salle is one of the few large metropolitan hotels that owns and operates a fleet of taxicabs and touring cars. You will be delighted with the promptness, quality, and economy of the service.

RUTH WHEELER, M.D.
Vice-President, American Dietetic Association
Professor of Home Economics, Goucher College, Baltimore, Md.

Other hotels in the vicinity will give you satisfactory service if you do not desire to stay at the headquarters hotel.

And of course you will want to see the exhibits. This year we have tried to cover all lines of especial interest to the members in the various fields, both in the commercial and in the non-commercial exhibit.

The latter feature will comprise bulletins, charts, requisition forms, menu forms, cost accounting sheets, menus, organization charts, posters, pictures, floor plans, and containers for sending out special diets.

In the commercial exhibit we can assure you of a few lines of foods put out by excellent firms, and a wide range of equipment put in by the leaders for quality in this line.

FINAL PROGRAM

The program follows, so that each one may judge of its value:

Monday, October 24, 1921

9:30 A.M. Section on Administration.
Mary A. Lindsley, Chairman, Manager, Grace Dodge Hotel, Washington, D. C.
Discussion of Questionnaire.
Mary A. Lindsley.
"Equipment."
By George A. Smith, Chicago Range Co., Chicago, Ill.

MARY DE GARMO BRYAN
President, American Dietetic Association
Jersey City, N. J.

"Administrative Problems."
By Agnes Gleason, Manager, Parkway Tea Room, Chicago, Ill.
"Salesmanship."
By Mildred Robinson, In Charge of Salesmanship, Chicago Public Schools, Chicago, Ill.

2:00 P.M. Section on Social Service.
Lucy Gillett, Chairman, Society for Improving the Conditions of the Poor, New York City.
"To What Extent Shall Racial Customs Enter Into Any Americanization Scheme."
By S. P. Breckenridge, Dean of Women, University of Chicago, Chicago, Ill.
Dietary Customs of Various Nationalities:
Syrians and Roumanians.
By Bessie Lee, Visiting Housekeeper Association, Detroit, Mich.

Jews.
By Mrs. Mary Schapiro, United Hebrew Charities, New York City.
Negroes and Mountain Whites.
By Fairfax Proudfit, University of Tennessee, Out-Patient Medical Department, Memphis.
Italians.
By Reba Reed, Association for Improving the Condition of the Poor, New York City.

6:30 P.M. Dinner Meeting.
President Presiding.
President's Address.
"Professional Spirit."
By Harriet Vittum, Northwestern University Settlement House, Chicago, Ill.
"Internal Hygiene and Its Relation to Food."
By Medison E. Bentley, Professor of Psychology, University of Illinois, Champaign, Ill.

RENA ECKMAN
Second Vice-President, American Dietetic Association, House Director, University of Michigan Hospital, Ann Arbor, Mich.

"Industrial Leadership."
By A. E. Morgan, President, Antioch College, Yellow Springs, Ohio.

Tuesday, October 25, 1921

9:30 A.M. Section on Education.
Dr. Ruth Wheeler, Chairman, Professor of Nutrition, University of Iowa Medical School, Iowa City, Iowa.
"What Nurses Need to Know About Food and Dietetics."
By Mrs. Higgins, Chief of Nursing Service, United States Navy Hospitals.
By Major Stimson, Chief of Nursing Service, United States Army Hospital.
Experience Meeting for Members Only.
Strictly two-minute speeches by ten dietitians.

E. M. GERAGHTY
Secretary, American Dietetic Association
Champaign, Ill.

Hospital Training of Dietitians:
In Rochester, Minn.
In Peter Bent Brigham Hospital, Boston, Mass.
In Johns Hopkins Hospital, Baltimore, Md.

ELLEN M. GLADWIN
Treasurer, American Dietetic Association
Jefferson Hospital, Philadelphia, Pa.

ESTHER ACKERSON FISCHER
President, Chicago Dietetic Association
Dietitian, Chicago Beach Hotel, Chicago, Ill.

2:00 P.M. Round Table Discussions.

1. Education.
   Conducted by Dr. Wheeler.
   Reports by Sub-Committees:
   A Course in Dietetics for Nurses.
   Preliminary Course for Dietitians in Universities, Colleges and Technical Schools.
   Hospital and Medical School Training for Dietitians.
2. Dietotherapy.
   Conducted by Rena Eckman, House Director, University Hospital, Ann Arbor, Mich.
   Activities in Dietotherapy—Laboratory Research and Clinical Application.
   Educational Propaganda—Fields of Greatest Need.
3. Social Service.
   Conducted by Lucy Gillett.
   "Cooperation in the Public Health Movement From a Medical Standpoint."
   By Blanche Joseph, Michael Reese Hospital, Chicago, Ill.
   From a Nursing Standpoint.
   From the Social Worker's Standpoint.
   By Florence Nesbit, Chicago United Charities, Chicago, Ill.
4. Administration.
   Conducted by Mary A. Lindsley.
   Discussion on Equipment, Labor, Supplies, and Food, led by Division Chairman.

The Presbyterian Hospital, Chicago, whose metabolism ward, under the direction of Dr. Woodyatt, will be of interest to the members of the American Dietetic Association.

The Gold Room, Hotel La Salle, where the exhibits of the American Dietetic Association will be displayed.

8:00 P.M. "The Sphere of the Dietitian."
By C. P. Howard, M.D., Professor of Internal Medicine, State University of Iowa, Iowa City, Iowa.
"Personnel."
By Hugh Fullerton, The H. Black Co., Cleveland, Ohio.

Wednesday, October 26, 1921

9:30 A.M. Fifteen Minutes Talks.
President Presiding.
"The Present Need for Cafeteria and Institutional Managers."
By Blanche Geary, Y. W. C. A., New York.
"The Hospital Dietitian."
By Marion Peterson, Swedish Hospital, Minneapolis, Minn.
"An Institutional Problem."
By Mabel Little, Director of Halls University of Wisconsin, Madison, Wis.
"The League of Business and Professional Women."
By Lena Phillips, Executive Secretary, National Federation of Business and Professional Women's Clubs.
Business Meeting.
2:00 P.M. Section on Dietotherapy.
Rena Eckman, Chairman.
The Dietary Needs of a Children's Hospital."
By A. L. Daniels, M.D., Iowa State Child Wel-

fare Association, University of Iowa, Iowa City, Iowa.

"The Newer Ideas on the Dietetic Management of Diabetics and Their Practical Working Out in the Hospital."

By R. T. Woodyat, M.D., Assistant Professor of Medicine, University of Chicago, Chicago.

8:00 P.M. Evening Meeting.

President Presiding.

"Relationship Between Diet and Nervous Conditions with Its Significance in Social Problems."

By Sydney Kuh, M.D.

"Systems of Follow-Up Work in Dietetics."

By Mrs. Gertrude Gates Mudge, Nutrition Service, American Red Cross.

"Human Engineering."

By Robert Wolf, Consulting Engineer, New York City.

COMMERCIAL EXHIBIT

In the exhibit room you will find well known beverages served in new ways; package meats; suggestions for utilizing less expensive cuts of meat; two types of dishwashing machines; heavy duty electrical equipment; two types of electric toasters; at least one excellent bread slicer; a mixing machine; fancy groceries and a few well known staple canned goods; two powders for all sorts of cleaning, one is very well known and the other is a new comer in the field; the people who wish to see their silver always bright may see in action a machine which is the most efficient on the market; then there will be china, glassware, silverware, linens, ranges, coffee urns, steam tables, and at least one food cart. I believe every hospital dietitian is interested in food carts!

Trips Planned by Chicago Association

The Chicago Dietetic Association feels that you will be interested in seeing Chicago with its many hospitals, its large commercial firms, its public health and infant welfare departments, and its many beautiful buildings and lovely parks. Therefore, we have set aside Thursday morning for a series of trips about Chicago. You will find them interesting and enjoyable and we hope you will plan to stay over that day and make it a part of your convention week.

Bearing in mind that you are not all hospital dietitians, or public health dietitians, or dietitians interested in the commercial field, we have planned the trips in such a way that you can select the one of most interest to you.

The trips are as follows:

(1) To commercial institutions: Sprague Warner's Wholesale House, Field's Tea Room, Swift's Packing Plant.

(2) To hospitals: Presbyterian Hospital, especially Dr. Woodyatt's Metabolism Ward; Cook County Hospital, kitchen equipment service in wards; and Sarah Morris Hospital at Michael Reese Hospital, milk laboratory.

(3) To welfare centers: Infant Welfare Society of Chicago, nutrition clinic; Association of Practical Housekeeping Centers; A Dispensary Nutrition Clinic.

The trips will be taken by automobile and will lead through Chicago's wonderful parks. The three groups will meet at the Chicago Beach Hotel for lunch, where we will have a

Field's tea room, where many of the delegates will wish to have luncheon.

nice restful place to eat and visit. After lunch we will go to the University of Chicago and see the interesting work being done in the food department, where the kitchens and equipment will be of interest to everyone.

The Presbyterian, another of Chicago's larger hospitals, accommodates five hundred and twenty-five patients.

In this hospital a special feature is the metabolism work of the Sprague Institute.

This institute has eight endowed beds in the hospital; four for men, and four for women. When in the hospital the patients are given treatment; are taught how to perform the necessary tests and how to manage their diets. After the patients go home the follow-up work is kept up through the dispensary.

Aside from the endowed beds there are other patients cared for through the Institute. Some fifteen hundred in all, throughout the community.

Another of Chicago's largest hospitals has about four hundred beds in the main hospital, and about one hundred in the building known as the Sarah Morris Hospital for children.

The hospital is well known for its splendid medical department, its school for nurses, and for its work in dietetics, especially the metabolic work.

Nutrition Clinic of the Infant Welfare Society of Chicago.

In the children's hospital there is a milk laboratory which is very completely equipped with modern electrical equipment such as pasteurizer, churn, Nixtmall mill, and Babcock machine for testing the fat content of milk. They are planning to have a demonstration in this laboratory the day we visit it.

Chicago's largest tea room is located in the largest department store in the world. The main tea room, occupying the entire seventh floor, is a block square. Besides this the men's grill takes up one entire floor in the men's building. Luncheon is served to several thousands every day in the various rooms, each one of an entirely different atmosphere. Tea is served in the Narcissus Room which is always delightful with its lovely fountain and its good music.

"To keep the well child well" is the slogan of the Infant Welfare Society. To do this there are twenty-six stations throughout the city where mothers may bring babies to be weighed and examined and to receive advice from the doctor and nurse in regard to the feedings.

Because of the greatness of the problem of saving the babies under twelve months, little or no attention has been paid to the child of pre-school age. The fact that there are 300,000 babies who die during the first year of life seems so overwhelming that we forget the fact that another 150,000 children die before they are five years old.

When the program for the pre-school child was started the question arose as to just who should carry the work. Specialization had meant so much to the infant welfare problem that the organization tried to secure people who were best fitted to work out this new program. Dietitians seemed to best fill this need, and seven dietitians who are specializing on the food problems of this two to six year group, have been added to the staff. Nutrition clinics are held weekly in eleven of the twenty-six stations. The child is weighed, measured and given a thorough physical examination by the doctor, and the mother is given feeding instructions by the dietitian at the clinic. This advice is followed up with home visits by the dietitian and nurse. The responsibility of the doctor and nurse is to see that the child is free to gain, and the responsibility of the dietitian is to see that the mother knows what will make him gain and then most effectively employs the means she has at hand to bring it about. Prenatal care is now given at four stations.

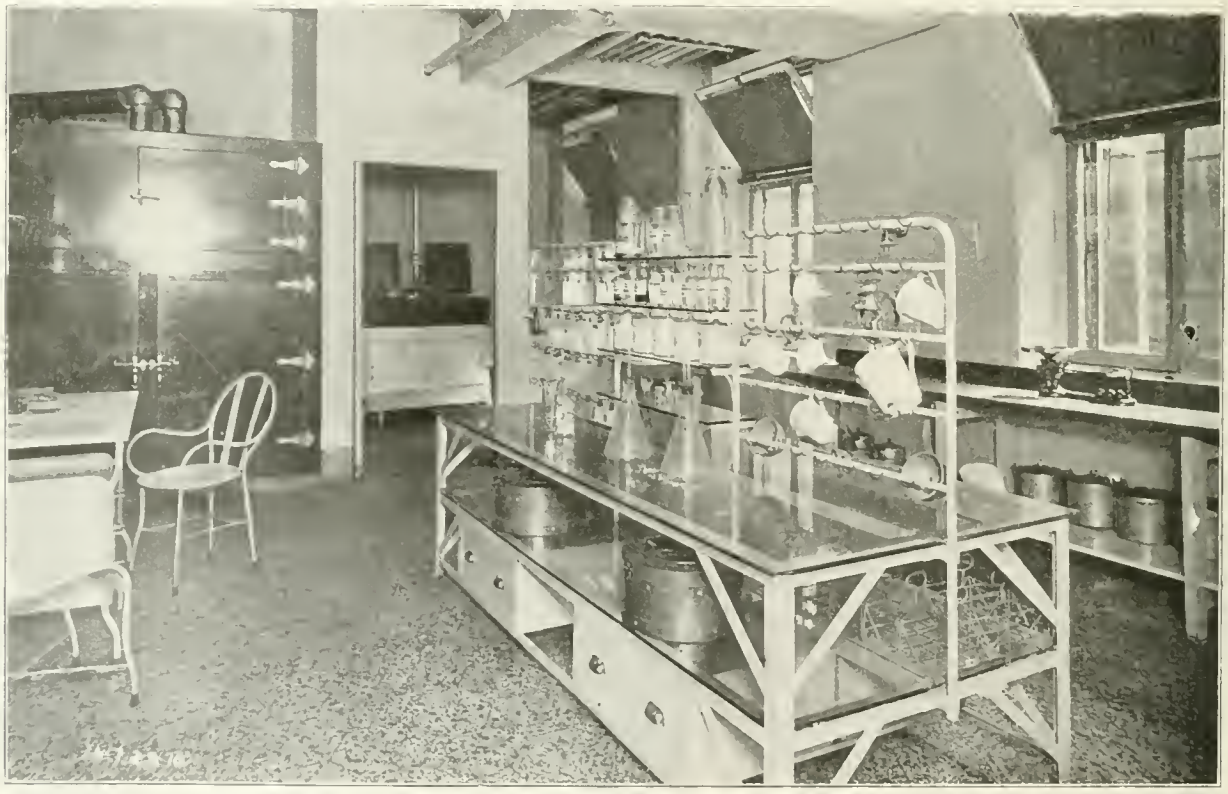
The number of children cared for is steadily increasing each year. The following table will show the growth:

Cared for: Dates	Babies	Children 2-6 yrs	Mothers
Jan. 1 – Aug. 1, 1920	6,890	615	425
Jan. 1 – Aug. 1, 1921	7,411	880	878

Nutrition clinics have been started in connection with the regular work of "teaching pupils to make their homes attractive and healthful as possible in the surroundings in which they live." They were organized to care for the children who wanted to go to work but who could not because of malnutrition. The most interesting feature of these clinics is the connection with the "flat." Here mothers have been shown how to cook the foods required to help the children gain in weight.

Beautifully situated at the east end of Hyde Park Boulevard right on Lake Michigan, is the Chicago Beach Hotel. Here it is possible to indulge in all the sports and activities of a seaside resort in summer and of an exclusive country club in winter and yet be but ten minutes ride from the heart of Chicago's shopping and theater district.

The Chicago Beach is known for its quiet and homelike atmosphere above all else. It is also famous for its cuisine and several dining rooms where guests may dine under varied delightful surroundings as though at different hotels. Reasonable prices will be found in each dining room and café.



The milk laboratory in the children's department of Michael Reese Hospital, where a demonstration will be given at the time the delegates visit this institution.

SALARIES HOSPITAL SUPERINTENDENTS ARE NOW RECEIVING

By JOSEPH J. WEBER and OTHO F. BALL, M.D., of The Modern Hospital, Chicago, Ill.

TO SECURE the information on which this paper is based, questionnaires were mailed to two groups of hospitals. One group consisted of hospitals having less than 100 beds; the other, of hospitals having 100 beds or more. Of the smaller hospitals, i. e., hospitals of less than 100 beds, 500 were selected from the country at large. In order to secure information that would represent every section of the United States, these 500 hospitals were distributed among the various states in the ratio which the population of each state bears to the total population of the United States, according to the Federal census of 1910. To illustrate, the population of New York State, approximately 10,000,000, is roughly one-tenth of the total population of the United States. New York State was, therefore, represented in the list to whom the questionnaire was sent by one-tenth, or fifty, of the total 500 hospitals. This principle was followed in distributing the entire 500 hospitals among the various states. By this method it was hoped to obtain, as nearly as possible, representative information of the salaries paid the superintendents of the smaller hospitals in every section of the country. Of these 500 institutions, 112, or 22 per cent, responded to the questionnaire.

The second group, i. e., hospitals of 100 beds or more, consisted of the 285 non-Catholic hospitals in the American College of Surgeons' 1920 list of approved hospitals. The hospitals in this list are widely distributed, not only throughout the United States, but also throughout Canada. Of these 285 institutions, 116, or 40 per cent, responded to the questionnaire.

Hospital Divided Into Two Groups

For the purpose of analyzing and comparing the salaries received by the executives of these hospitals, we have divided the 112 hospitals in the first group into the following three subdivisions:

1 to 49 beds; 50 to 74 beds; 75 to 99 beds.

The 116 hospitals in the second group, ranging in capacity from 100 to 2,700 beds, we have divided in the following subdivisions:

100 to 199 beds; 200 to 299 beds; 300 to 399 beds; 400 to 499 beds; 500 and more beds.

Salaries of Men and Women Considered Separately

First of all, it must be admitted that the principle of equal pay for equal service does not find general application in the salaries of hospital superintendents. Women, on an average, receive lower salaries than men superintendents. To present averages of the combined salaries of men and women would, therefore, give an exceedingly false impression of the situation; on the one hand, reducing the average salaries of the men, and on the other hand, increasing the average salaries of the women. The salaries of men and women superintendents will, therefore, be dealt with separately.

As was to be expected, women predominate as superintendents of the smaller hospitals, there being eighty-nine women to twenty-three men; while men predominate as superintendents of the larger institutions, there being eighty-five men to thirty-five women. Twenty-five of these thirty-five women, moreover, are superintendents of hospitals of 100 to 199 beds, the group that lies just above what we choose to call the smaller hospitals, i. e., institutions having less than 100 beds.

One of the most interesting things revealed by this study is the fact that in many of the subdivisions a relatively small number of superintendents receive salaries that are above the average salary for their subdivision, while a relatively large number receive salaries that are lower than the average salary for their subdivision. This is true of both men and women superintendents. In the fifty to seventy-four bed subdivision, for example, the salaries of forty-three of the fifty-six women are below the average. In the 100 to 199 bed subdivision, the salaries of sixteen of the twenty-five women and fourteen of the twenty-five men are below the average.

Highest Salaries Paid

The highest salary paid a woman superintendent among the 228 hospitals from which information was secured, is $5,400, the executive of a 150 bed hospital; the lowest, $1,200, the executive of a ninety bed hospital. The highest salary paid a man superintendent is $18,000, the executive of a 485 bed hospital; the lowest, $1,740, the executive of a sixty bed hospital.

The superintendents of but two of the smaller hospitals receive $5,000 or more. Among the larger hospitals, 46 per cent of the superintendents receive $5,000 or more.

The average salary of the women superintendents in the three subdivisions of the smaller hospitals ranges from $2,220 to $2,530, the minimum individual salary being $1,200, the maximum $4,000.

Of the thirty-one women superintendents of the larger institutions, twenty-five, as already indicated, are superintendents of hospitals with a capacity of from 100 to 199 beds, and receive an average salary of $2,899; five are superintendents of hospitals with a capacity of 200 to 299 beds, and receive an average salary of $3,795; and one is the superintendent of a 471 bed university hospital, and receives a salary of $3,484.

The average salaries of the eighty-five men superintendents in the various subdivisions of the larger hospitals range from $4,650, paid the superintendents of hospitals of 100 to 199 beds, to $7,604, paid the superintendents of hospitals of 400 to 499 beds.

If you are the superintendent of a hospital supported by private funds, as distinguished from a municipal or county hospital, your salary is likely to be more lucrative than if you are the superintendent of a hospital supported by the public treasury. For instance, the average salary of the twenty-two men superintendents of the hospitals supported by private funds in the 200 to 299 bed subdivision, is $1,577 more than the average salary of the superintendents of the five city and county hospitals in this subdivision; $2,000 more than the average salary of the superintendents of the three city and county hospitals in the 300 to 399 bed subdivision, and $776 more than the average salary of the superintendents of ten of the largest city and county hospitals in the United States.

To come to any constructive conclusions from a study of this rather diversified data is not easy. This fact, however, is plainly evident: there is no approach to standardization; indeed there is no evidence to indicate the

recognition of even minimum standards for the superintendents of institutions of various capacity and character of service. Some superintendents receive relatively high salaries, while many others, who serve hospitals of like capacity and service, are receiving much less. For example, the difference between the minimum and maximum salaries among the men superintendents of the 100 to 199 and the 200 to 299 bed groups is about $9,000; in the 400 to 499 bed group, about $15,500, and in the group of 500 beds and over about $6,000.

We found ourselves somewhat at a loss to find a basis upon which to compare the salaries of hospital superintendents with the salaries of those in other professional fields. Perhaps the position of hotel manager approximates more closely than any other the position of the superintendent of a hospital, although one must not forget that the superintendent, in addition to performing all the duties of a hotel manager, has certain other, often difficult, duties that are inherent in the management of an institution devoted to the care and treatment of the sick, and for the acceptable performance of which he can qualify only after prolonged training and experience. So far as we are aware, no systematic attempt has ever been made to study the salaries of hotel managers, by and large. From the meager information available, it seems that the salaries of hospital superintendents, in many instances, compare favorably with the salaries paid the managers of hotels. We are informed by the editor of one of the leading hotel journals, that from $3,000 to $4,000 and maintenance is now regarded as a fair salary for the manager of a hotel of average size; and that salaries of $5,000 and $7,500 are exceptional, and are paid managers of the largest metropolitan hotels.

Detailed Information Regarding Salaries Paid Superintendents of 112 Hospitals Having Less Than 100 Beds

Range of Bed Capacity of 112 Hospitals—20 to 97 Beds.

1 to 49 Bed Group

Twelve hospitals, or 11 per cent, of 112 hospitals under consideration.

Number of men superintendents	4
Number of women superintendents	8
**Average salary of women superintendents*	$2,220
Minimum salary of women superintendents	1,500
Maximum salary of women superintendents	3,210
Salaries below average	2
Salaries above average	4
**Indeterminable	2
Average salary of men superintendents	$2,445
Minimum salary of men superintendents	1,800
Maximum salary of men superintendents	3,000
Salaries below average	2
Salaries above average	2

50 to 74 Bed Group

Sixty-six hospitals, or 59 per cent, of 112 hospitals under consideration.

Number of men superintendents	10
Number of women superintendents	56
Average salary of women superintendents	$2,530
Minimum salary of women superintendents	1,500
Maximum salary of women superintendents	4,000
Salaries below average	43
Salaries above average	7
Indeterminable	6
Average salary of men superintendents	$2,316
Minimum salary of men superintendents	1,740
Maximum salary of men superintendents	3,000
Salaries below average	5
Salaries above average	5

75 to 99 Bed Group

Thirty-four hospitals, or 30 per cent, of 112 hospitals under consideration

Number of men superintendents	9
Number of women superintendents	25
Average salary of women superintendents	$2,492
Minimum salary of women superintendents	1,200
Maximum salary of women superintendents	3,600
Salaries below average	16
Salaries above average	9
Average salary of men superintendents	$3,827
Minimum salary of men superintendents	2,400
Maximum salary of men superintendents	5,600
Salaries below average	6
Salaries above average	3

Detailed Information Regarding Salaries Paid Superintendents of 116 Hospitals Having 100 or More Beds

Range of Bed Capacity of 116 Hospitals—100 to 2,700 Beds.

100 to 199 Bed Group

Fifty hospitals, or 43 per cent, of the 116 hospitals under consideration.

Number of men superintendents	25
Number of women superintendents	25
Average salary of women superintendents	$2,899
Minimum salary of women superintendents	1,260
Maximum salary of women superintendents	5,400
Salaries below average	9
Salaries above average	9
Indeterminable	7
Average salary of men superintendents	$4,650
Minimum salary of men superintendents	2,040
Maximum salary of men superintendents	11,500
Salaries below average	12
Salaries above average	11
Indeterminable	2

200 to 299 Bed Group

Thirty-two hospitals, or 28 per cent, of the 116 hospitals under consideration.

Number of men superintendents	27
Number of women superintendents	5
Average salary of women superintendents	$3,795
Minimum salary of women superintendents	2,865
Maximum salary of women superintendents	4,620
Salaries below average	2
Salaries above average	1
Indeterminable	2
Average salary of men superintendents	$6,716
Minimum salary of men superintendents	3,000
Maximum salary of men superintendents	12,000
Salaries below average	13
Salaries above average	11
Indeterminable	3

300 to 399 Bed Group

Five hospitals, or 4 per cent, of the 116 hospitals under consideration.

Number of men superintendents	5
Average salary of men superintendents	$4,850
Minimum salary of men superintendents	4,200
Maximum salary of men superintendents	5,500
Salaries below average	2
Salaries above average	3

400 to 499 Bed Group

Twelve hospitals, or 10 per cent, of the 116 hospitals under consideration.

Number of women superintendents	1
Number of men superintendents	11
Average salary of men superintendents	$7,604
Minimum salary of men superintendents	2,400
Maximum salary of men superintendents	18,000
Number whose salary is below average	6
Number whose salary is above average	4
Indeterminable	1

500 Beds and Over

Seventeen, or 15 per cent, of the hospitals under consideration.

Number of men superintendents	17
Average salary of men superintendents	$6,962
Minimum salary of men superintendents	4,100
Maximum salary of men superintendents	10,250
Salaries below average	7
Salaries above average	7
Indeterminable	3

*Where maintenance constitutes a part of the compensation, its estimated monetary value is included.

**Indeterminable because maintenance was not estimated in dollars and cents.

Salaries of Superintendents of 112 Hospitals Having Less Than 100 Beds

No. of Beds	Sex of Superintendent	Monetary Salary	Monetary Equivalent in Board, Room and Laundry
1 to 49 Bed Group			
20	F	$1,800	$360
30	M	2,700	0
30	M	3,000	0
33	F	1,500	360
35	F	1,800	Not estimated
35	F	1,360	480
36	M	$1,800	0
36	F	1,500	Not established
40	F	2,400	$800
40	F	1,800	480
40	M	1,800	480
45	F	1,800	360
50 to 74 Bed Group			
50	F	$1,800	$1,200
50	F	1,320	0
50	F	1,800	600
50	F	1,500	540
50	F	1,800	0
50	F	1,800	780
50	F	1,500	525
50	F	1,800	1,680
50	F	1,800	360
50	M	1,500	400
50	F	1,500	0
50	F	1,500	480
50	F	2,500	1,500
50	F	1,500	1,200
50	F	1,800	500
50	F	2,400	900
50	F	1,500	Not estimated
50	F	1,500	Not estimated
50	F	1,800	480
50	F	1,200	600
50	F	1,200	540
50	F	2,400	780
50	F	1,500	600
52	F	1,800	600
52	F	1,800	Not estimated
53		44,520	15,345
54	F	1,800	300
54	F	3,600	0
55	F	1,680	480
56	F	1,800	480
56	F	1,800	480
57	M	3,000	0
60	F	1,500	384
60	M	$1,800	0
60	F	1,400	500
60	F	1,800	600
60	F	1,320	600
60	M	1,740	0
60	F	1,500	600
60	F	1,500	0
60	M	2,160	0
60	F	3,000	720
60	F	2,000	1,000
60	M	2,700	260
62	F	1,800	260
65	F	2,100	Not estimated
65	M	2,520	0
65	F	1,800	416
65	F	2,100	Not estimated
65	F	1,800	365
65	F	1,800	700
65	F	2,400	1,560
65	F	1,980	1,020
66	F	2,100	900
68	F	1,800	480
70	F	1,500	300
70	M	2,400	360
70	F	1,500	480
70	F	1,500	365
70	F	3,000	Not estimated
70	F	2,700	0
70	F	1,500	900
70	F	1,800	0
70	M	1,200	540
70	M	2,100	600
72	F	1,800	600
75 to 99 Bed Group			
75	F	$1,800	$ 360
75	F	2,000	780
75	M	1,800	600
75	F	1,500	0
75	F	1,080	360
75	M	5,000	600
75	F	2,400	750
75	M	2,400	780
75	F	1,500	600
75	F	2,000	600
75	F	1,500	365
75	F	1,800	720
75	F	1,800	0
80	F	1,500	720
80	M	2,100	900
80	F	1,500	Not estimated
80	F	1,800	0
80	F	$1,800	0
82	F	1,800	500
85	F	2,000	960
85	M	3,600	1,200
86	M	5,000	0
86	M	3,000	0
87	F	2,400	0
87	F	3,000	600
88	M	2,500	0
90	F	1,200	0
90	F	2,000	0
90	F	1,800	720
90	M	2,700	150
90	F	1,800	900
90	F	2,400	720
90	F	2,400	200
97	F	1,380	720

Salaries of Superintendents of 116 Hospitals Having 100 or More Beds

No. of Beds	Sex of Superintendent	Monetary Salary	Monetary Equivalent in Board, Room and Laundry
100 to 199 Bed Group			
100	F	$1,500	B. R. & L.
100	F	2,250	Not estimated
100	M	3,000	1,800
100	F	900	360
100	M	3,000	0
101	M	4,500	0
110	M	8,500	3,000
115	F	1,560	660
119	F	2,400	900
120	M	2,500	0
120	F	1,800	780
125	M	4,000	960
125	F	1,680	660
125	F	2,000	540
125	M	4,500	0
125	F	2,400	480
135	F	2,100	0
137	M	6,000	1,000
140	M	3,000	2,000
140	F	2,400	600
140	F	2,770	1,385
142	M	2,100	Two meals
142	M	2,500	Pt. time service
145	M	4,000	100
145	F	2,100	Two Rms., bath
150	M	$3,000	$ 600
150	F	2,200	1,440
150	F	1,800	600
150	F	4,500	900
150	M	7,500	0
150	F	3,000	Two Rms., bath
150	M	3,600	1,400
150	M	5,000	480
150	M	2,580	730
150	F	2,700	Two Rms., bath
150	F	2,300	360
150	F	2,400	500
150	F	2,400	600
150	M	2,700	700
155	M	6,000	0
160	F	2,100	B. R. & L.
160	F	2,000	416
160	M	3,600	0
170	M	5,000	0
170	M	2,500	1,800
174	M	3,000	420
175	M	1,440	600
180	F	2,400	B. R. & L.
185	F	2,400	1,000
192	M	6,000	0
200 to 299 Bed Group			
200	M	$3,600	B. R. & L.
200	F	2,310	$2,310
200	M	3,600	1,000
200	M	6,000	2,000
200	F	2,500	365
200	F	3,000	600
200	M	3,360	0
200	M	3,000	Not estimated
210	M	3,430	1,715
215	F	3,000	900
225	M	5,000	0
225	M	7,500	3,000
236	M	9,000	200
240	M	2,400	Room and bath
250	M	12,000	0
250	M	5,000	Maintenance
250	M	$4,800	$200
250	M	6,000	2,400
250	M	3,600	1,000
255	M	10,000	0
256	M	3,500	2,600
269	M	5,000	180
265	M	4,800	1,200
267	M	7,500	0
270	M	6,000	2,000
273	M	5,000	5,000
275	M	3,600	Maintenance
275	M	5,000	3,000
285	M	6,000	0
291	M	5,000	2,000
295	M	8,000	2,000
300 to 399 Bed Group			
300	M	$5,000	0
320	M	4,500	0
350	M	2,700	$1,500
360	M	$4,000	$1,000
360	M	4,500	1,000
400 to 499 Bed Group			
100	M	$2,400	0
404	M	9,000	$350
446	M	8,000	0
450	M	4,500	1,200
450	M	7,200	0
450	M	4,800	0
450	M	$6,500	0
471	F	3,000	$484
476	M	4,200	B. R. & L.
480	M	5,000	0
485	M	12,000	6,000
494	M	12,500	0
500 Beds and Over			
500	M	$5,000	$3,600
500	M	7,500	House only
625	M	7,500	2,500
700	M	2,400	1,700
770	M	5,000	0
850	M	4,500	2,000
850	M	4,600	1,800
900	M	3,600	2,400
1110	M	4,750	2,375
1,209	M	$3,750	$1,500
1,202	M	6,500	2,500
1,550	M	6,000	1,200
1,600	M	6,250	4,000
1,800	M	2,200	Maintenance
1,837	M	5,050	0
1,900	M	4,000	3,000
2,700	M	4,000	Maintenance

FORM ROTARY SECTION OF THE AMERICAN HOSPITAL ASSOCIATION

The organization of a Rotary Section of the American Hospital Association was perfected at a luncheon meeting held at West Baden, on Thursday, September 15, with Mr. Pliny O. Clark of Denver, Colo., as chairman, and Mr. Frank E. Chapman of Cleveland, Ohio, as secretary. The section is composed of members of the American Hospital Association, who also have membership in Rotary clubs, and includes both hospital superintendents and exhibitors. Twenty-seven Rotarians were present at the organization meeting, representing all parts of the United States and Canada.

The section decided to petition the International Association of Rotary clubs to stimulate local Rotary clubs throughout the country, to invite hospital superintendents into membership, thereby bringing the hospital in close touch with the civic and commercial interests of the community. The establishment of a hospital section in the international association of Rotary clubs was also requested.

Active participation of Rotary clubs in hospital and health work was amply demonstrated by the reports of Mr. Frank E. Chapman of Cleveland, Mr. Anthony Tall of Elyria, Ohio, Mr. C. B. Hildreth, and other Ohio Rotarians, concerning the Ohio Society for Crippled Children, with its program of legislation, clinics, dispensaries, and hospitals, conducted entirely by forty-six Rotary clubs in the state of Ohio.

Dr. M. T. MacEachern of Vancouver, B. C., outlined the thorough-going tuberculosis program of the Vancouver Rotary Club, which includes diagnostic clinics, open-air schools, public health nursing, summer camps and sanatorium follow-up.

Those attending the meeting pledged themselves to make an effort to interest their local clubs in a constructive hospital or health program.

AMERICAN COLLEGE OF SURGEONS ANNOUNCES HOSPITAL CONFERENCE

Readers of THE MODERN HOSPITAL will take keen interest in the announcement made by the American College of Surgeons of a hospital conference, to take place at the Bellevue-Stratford Hotel in Philadelphia, October 24, the first day of the Clinical Congress of Surgeons.

The work of this body in the standardization of hospitals is already familiar to hospital executives and the decision of the College to devote one day to hospital problems is not only a wise, but a welcome, one. A program has been prepared, in which leading hospital associations will be represented. Timely, informative discussions on vital phases of hospital service will be given by leaders in the field. The day's program will terminate in a round table discussion in which hospital superintendents, staff and board members are urged to participate.

At this time the American College of Surgeons will release the list of approved hospitals for 1921.

The tentative program follows:

CLINICAL CONGRESS OF AMERICAN COLLEGE OF SURGEONS

Hospital Day, October 24

9:30 A.M. Hospital conference, dealing with the standardization program of the American College of Surgeons, including its present and future status.

Representative speakers from the following organizations have been invited to participate: The American Hospital Association, the Catholic Hospital Association, the Protestant Hospital Association, the Methodist Hospital Association, Provincial Hospital Associations of Canada. the Association of American Railway Surgeons, as well as various surgeons, hospital superintendents, and members of boards of trustees.

2:30 P.M. 1. The Industrial Hospital—This subject will be presented by two representative speakers, followed by a general discussion.

2. The Nursing Problem—What shall be the standard curriculum for hospital nurses? Shall there be a lower standard for the so-called "practical nurse"? Shall there be supplementary training for nurses desiring administrative or other special positions?

These subjects will be developed by a small group of hospital superintendents, officials of various nursing organizations, and hospital staff members.

4-5 P.M. General Round Table on "What Constitutes Good Service to the Patient," conducted by a group of hospital superintendents and staff surgeons.

TO ESTABLISH PUBLIC HEALTH SCHOOL

Plans for the organization of a School of Public Health in Harvard University, with the aid of an initial gift of $1,785,000 by the Rockefeller Foundation, were announced by the University and the officers of the Foundation.

An excellent general course for the training of public health officers, as well as special courses in preventive medicine, in tropical medicine, and industrial hygiene, have already been developed at Harvard. The work has been hampered, however, by lack of adequate funds, and by uneven growth.

The new school will provide opportunities for research, will unify existing courses, and will offer new or extended teaching facilities in public health administration, vital statistics, immunology, bacteriology, medical zoology, physiological hygiene, and communicable diseases.

For the housing of the school, the University hopes to secure an existing building of very suitable character immediately adjacent to the Medical School. Funds for the purchase and equipment of the building will be drawn from the gift of the Rockefeller Foundation.

The cost of maintenance and development of the school will be met from endowment funds in part set aside by the University and in part contributed by the Foundation. The Foundation's immediate appropriations to the project will aggregate $1,785,000. The arrangement also provides for further gifts, if the growth of the school seems to demand it, to any amount not exceeding $500,000.

Though the School of Public Health at Harvard will have its headquarters in a well-equipped building of its own and have its own separate faculty and administration, it will be developed in close relations with other divisions of the University, especially the Medical School.

The administration buildings of the two schools will, it is hoped, stand side by side on the same grounds; certain heads of departments will be members of both faculties; and a number of laboratories and lecture rooms will be used in common.

The school will be able to cooperate with a large number of laboratories, hospitals, and public health agencies in Boston, and thus afford its students unusual opportunities for investigation and practical field experience.

In addition, the school, through cooperative relations with a number of manufacturing and commercial corporations, will be able to offer the students practical experience in industrial hygiene.

OPENINGS IN ARMY SCHOOL OF NURSING

Two hundred openings exist for young women ambitious to take a three year course of nursing in the Army School of Nursing, as announced by the Army Medical Department. Applicants as young as nineteen years will be given consideration if physically matured, unmarried and otherwise qualified. The government allows the young women students $24 per month, which is calculated to cover the cost of uniforms and other incidental expenses. Board, quarters, and laundry are supplied by the army. Those appointed to take the course will be furnished with government transportation and sent to Walter Reed General Hospital, Washington, D. C., from states east of the Mississippi. Applications will be passed upon in the office of Major Julia C. Stimson, Army School of Nursing, Washington, D. C., to whom inquiries may be addressed for further information.

NATIONAL HEALTH COUNCIL REPORTS

During the special session of the Sixty-seventh Congress, there have been introduced 121 bills which relate to public health. This information comes from the National Health Council, which has issued eleven bi-weekly legislative statements covering the period from last April until August 24, when a recess was taken for a month. Statement No. 11, which is dated August 25, is a twenty page review and index number. Included in it are references to hospital legislation. Although these reports on national legislation were primarily intended only for members of the Council, the demand for them from outside organizations has been so great that arrangements have been made to supply them at cost price, twenty cents an issue. The reports are prepared and distributed by Mr. James A. Tobey, Washington representative of the National Health Council, 411 Eighteenth Street, N. W., Washington, D. C.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Director, Department of Nursing Education, College for Women,
Western Reserve University, Cleveland, Ohio

MORE "HOMELIKENESS" FOR NURSES' HOMES

BY MARY M. ROBERTS, R.N., ROCHESTER, N. Y.

WHAT kind of a nurse do *you* like when you are sick? Would you willingly submit to the ministrations of a physically tired and mentally inert person, even though highly skilled, if you thought it possible to secure the services of a nurse who could talk something besides "shop," and who had a reserve of physical energy that seemed more than sufficient to carry you both through any crisis? These are questions worthy of consideration not only by the nurse employing public, but also by the tax paying and the philanthropic public; in fact by all those who are in any way responsible for the existence of nurses who, after all, do exist only because of community needs.

Why are not the right kind of women entering the nursing profession? One reason is that they believe that nursing is "all work and no play." They hear of students who have left training schools after a few weeks, during which time they "nearly died of lonesomeness." Schools for nurses are not making proper provision for normal home life and recreation for their students. Something of this could be learned from colleges.

Instruction and recreational facilities should be divorced as in colleges. The nurse cannot shake off her responsibilities if she remains under the roof of the hospital during her hours off duty. Classrooms should not be placed in the nurses' home. Single rooms should be provided for the students, living rooms should be homelike and inviting. Roofs are sometimes used to great advantage for outdoor sleeping and recreational purposes.

The demand for the highly qualified American nurse with all her initiative and independence is rapidly becoming world wide, and we fall far short of meeting the demand at home. Large numbers of young women should be prepared for this intensely interesting phase of social work if we are to compete with our own health standards, but—they are not offering themselves. A college student who expects to enter this field was asked why so few of her friends had similar plans. The answer, since corroborated by a considerable group of students, was to the effect that too few hospitals seemed to offer their students a reasonable home life with normal opportunities for relaxation and recreation. As a corollary they added that schools making such provision failed to give sufficient publicity to the fact, and a mistaken notion that nursing is "all work and no play" is allowed to persist. Their judgments were based largely on fragmentary statements such as the rather common one, "I thought I should die, I was so lonesome," of the girls who dropped out after a few weeks' preliminary work. Sympathetic parents also have spread this sort of misconception. For example, they invariably interpret the student's enjoyment of an occasional meal at home as a sign of comparative famine in the hospital, quite forgetting that the good hospital offers the same charm of novelty to the girl at home. Many a nurse, now successful, admits that she packed her trunk for departure more than once during her training, but, as this could usually be accomplished only at night, always had sufficient courage in the morning to combat the homesickness for another day.

College students suffer from similar ills but not so acutely that they drop out in large numbers! It seems logical, therefore, to assume that some of the difficulties could be avoided by adopting the principles that control dormitory life in the college. This is by no means as difficult as it at first appears. Begin by divorcing instruction and recreational activities. The hospital is the laboratory of the school for nurses. Let us, then, remove our students as far as possible from this atmosphere when their laboratory periods, in other words, their hours of duty, are over. Few colleges now think of combining laboratories and dormitories under one roof. And yet the laboratory material of the college is mere inanimate matter, while the laboratory material of the hospital is the sentient, suffering human being who must be safeguarded from annoyance at all hazards. Those who have tried it, know that the ideal of comfort for the patient, and freedom for relaxation and self expression for the nurse cannot be realized under one roof. Separate homes should be provided, and in most instances this is being done, though not always adequately. Within the year, however, a lecturer, whose statements should carry the weight of authority, has advocated putting accommodations for nurses on the upper floors of institutions. This because land, in cities, is valuable. Is land really more valuable than good nursing for a city's sick? Surely all concerned would agree that better nursing can be provided by groups of healthy, happy, active-minded women than by a repressed group, assuming that in this age of self expression, the repressed group is available.

Hospitals now under construction and embodying many splendid ideas for the care of the sick are planning to use upper floors in this way. Undoubtedly such quarters can

be well adapted to many of the requirements of the nurses' home. The rooms will certainly be light and airy and can be made attractive, but always, just one floor below, there will be patients who must not be disturbed. Elevators, in common use by patients and nurses, will carry the sense of responsibility and repression to the very doors of the nurses' rooms and the responsibility for human comfort—even for human life—is not so easily shut out. In justice to the patients it should be shut out in order that the nurse may return to duty refreshed and really ready for any emergency that may arise. Hospitals are sincere in calling this an expedient, and in planning to abandon the scheme at some future time, but in view of the reluctance of applicants to put up with expedients, the wisdom of the plan seems open to question.

Class Rooms Should Not Be in the Home

Since separate homes are generally conceded to be desirable, what are the essential features? Following the argument that what applies to the college should also apply to the school of nursing implies that no teaching should be done in the home, residence, or hall, whatever be its official title. This is a moot question involving the whole status of the school in the hospital. It would seem trite to remark that no school could exist without classrooms did we not know how pathetically often this situation has confronted superintendents in the past. Let us say at once that they do not belong in the home; but, until such time as our schools are endowed or granted suitable budgets, it is probable that, in the interests of education, classrooms will be so placed. The requirements for good teaching have been enumerated many times. It is sufficient here to say that, if they are put in the home, they should be planned generously and for future growth and not grudgingly as an after thought.

Single Rooms Not a Luxury

The question of the architect who is to draw up the plans will be, "What do you want to provide for?" For the answer, let us go back to the prospective student and her parents. What are they justified in expecting for the student who "pays her way" in services rendered the hospital? Single rooms sound like luxury to many people who fail to realize how intense the physical, intellectual, and even emotional demands of the hours on duty may be. After eight or ten hours of it, privacy is essential if the student is to come back day after day with all her powers fully at the disposal of her patients. Emphasis on this point is still necessary, for plans published quite recently show that dormitories of six or eight beds are still being built. Let the rooms be as simple as possible in furnishings, for simplicity, good taste, and economy may very properly go hand in hand.

The supply of baths and lavatories requested usually seems extreme to the uninitiated, who conclude that nurses are a curious sort of amphibious animal. Soap and water are, paradoxically, not only a cheap but a valuable disinfectant, and running water in every room is by no means a luxury. Hundreds of nurses who have stood in line, towels and toilet equipment in hand, in the gray dawn, will testify to the effect on disposition of a too oft repeated experience of the sort. What of the effect on the patients of the nurse who, instead of appearing with a "shining morning face" and a cheerful greeting, starts her day (and the patient's) in a depressing silence and quite under the impression that she is exercising "a noble self control"?

If the home is a large one, the dining room and kitchen may well be under the same roof. The fairly wide use of the cafeteria plan seems to be the result of necessity rather than conviction in most instances. Whatever the plan, the arrangements should be as cheerful and attractive as possible. The coaxing of patients' appetites should be all that sort of discipline required of our students.

Have Livable Living Rooms

Having provided for the fundamental needs of eating and sleeping, let us now turn our attention to that which our prospective student considers of equal importance,—the provision for recreation. Practically every description of a nurses' home begins with a description, or some statement regarding the unusual, or spacious, or handsome reception room. These are admirable qualities if they are not gained at the expense of other equally necessary rooms. Unfortunately the provision for social gatherings is frequently limited to this one room. If it has been cleverly planned with pillars and alcoves, several groups may use it at one time, but too often it is avoided by graduates because they feel the students should be free from any sense of supervision, and by the pupils because they do not care for the somewhat formal surroundings except on formal occasions. Ample provision should be made for students to entertain guests in at least semi-privacy. No one thing will do more for the morale of a school than this. Let us here also make a plea for a smaller reception room for the graduate staff, or faculty, of the school; and for rooms on the upper floors that invite, by their very simplicity, informal gatherings of graduates and students. A faculty sitting room, on an upper floor, adds much to the comfort and *ésprit de corps* of this frequently overlooked group. We have faculty clubs and student clubs in our most democratic colleges. Should we not accord the same privileges to the various groups in the school for nurses? Tiny kitchenettes near these rooms can be equipped at slight expense, thus providing for the informal cup of tea to which all feminity is supposed to be addicted.

A reference library is, of course, an essential for any school, but the importance of fiction and current literature is too apt to be overlooked. Genuine cooperation with public libraries can usually be secured if the matter is properly placed before them.

Roofs May Be Used

Many homes make excellent use of their roofs for outdoor sleeping, and for recreational purposes. In the warmer parts of the country, sleeping porches are sometimes provided; even in cities tennis courts are frequently possible, and a few really luxurious homes are provided by generous donors with gymnasiums and swimming pools.

Whatever the provision for recreation, much depends upon the spirit that pervades the home. Whether supervision is in the hands of a "house mother" or of a social director matters little if she really understands—not nursing, but young women. A person who can plan and "put across" an impromptu stunt on the night when a wave of discouragement seems to have swept over the whole place, is even more valuable than one who can plan a party or an elaborate amateur performance, such as "Hospital Life," a delicious travesty played in one school. This performance is really worthy of mention as all the personnel came in for its share of banter, and every patient was eager to know if it went well. The down-at-the-heel ward maid, the newest and therefore most dignified intern, the director of nurses herself, with her funny habit of twitching certain parts of her uniform, vied with each other for honors. Until the climax came, when a ward scene was reproduced in which a toothless and world-worn old

"chronic" fresh from her bath and clad in that ugliest of all human habiliments, a ward wrapper, greeted the august attending physician with, "Doctor, don't I look like Venus arising from the sea?"

This sort of thing may seem frivolous to those who talk much and give little real thought to nursing as a "noble profession." It must constantly be remembered that fine though they are, our students are very human young women—the public wouldn't really want angels if it could get them—and must have the same opportunities for social development, for entertaining and being entertained, for relaxation, and for stimulation that their sisters demand at home or in the colleges.

Proof of the value of a generous plan should be sought, not in the nurses' homes, but in the wards of hospitals having good homes. There will be found the end results of all our efforts, educational and social, the atmosphere of cheer and well-being that surrounds the patients skillfully cared for by nurses whose courage, optimism, and efficiency are fully at the disposal of their patients, and not constantly sapped by personal struggle with unsatisfactory conditions. The tone of these wards, and the cheerful recovery of patients, more than repay the hospitals, and those supporting them, for the increased expenditure involved in intelligent care of nurses.

JUBILEE AT ST. THOMAS' HOSPITAL

The annual garden party of the Nightingale Training School for Nurses to "Old Nightingales," was a most charming function. The day, June 21, was the fiftieth anniversary of the opening of St. Thomas' Hospital, London, on its present site. The hospital itself has been in existence for about eight hundred years.

Two memorable events occurred: In the first place, H. R. H. the Duke of Connaught came onto the lawn where all the nurses of the Nightingale school and their guests were assembled, and under the shadow of Big Ben

presented prizes to the medical students, and received from the matron, Miss Lloyd Still, the offering of £2,000 or about $8,000 given and collected by the nurses towards the Hospital Appeal Fund.

In the second place, the group of international students who have just finished their course in public health nursing given at Kings College for Women under the auspices of the League of Red Cross Societies were there to be presented with beautiful commemorative bronze medals of those two rare women and rare friends, Edith Cavell and Madame Marie Depage. Madame Depage lost her life in the sinking of the Lusitania. The medal bears on one side the heads of these heroic women; and on the reverse side, the words "1915—Remember."

The presentation took place in the nurses' dining room in the Nightingale Home. Dr. Depage in making the presentation spoke in French and Miss Alice Fitzgerald, chief of the Division of Nursing of the League of Red Cross Societies returned thanks in French.

Among the guests on the beautifully decorated lawn were many distinguished "Nightingales" and other well-known members of the nursing profession from many countries.

PUBLIC HEALTH SERVICE TO HAVE TRAINING SCHOOL FOR NURSES

A training school for nurses of the United States Public Health Service is to be established by the Surgeon-General, which will offer to women desiring to take up the profession of nursing, a course of study leading to a diploma and an opportunity to assist in caring for disabled military patients.

The headquarters of the school is in the office of the Surgeon-General, Washington, D. C. Training will be given in certain hospitals in the Service. Schools will open on Sept. 1, at Fort McHenry in Baltimore, and at Fox Hills, Staten Island, N. Y. The service hospitals provide experience in surgical nursing, including orthopedic, eye, nose and throat; medical, including communicable, nervous, and mental diseases; x-ray and laboratory technique; experience in the diseases of children, and public health nursing. Gynecology and obstetrics will be provided in the second or third year of the course through affiliations with civilian hospitals. Lectures, recitations, and laboratory work will be given in the required subjects in each hospital training school.

The course will be three years. A credit of nine months, or approximately an academic year, will be given to graduates of accredited colleges. Credit of three or more months will be given to students who have had two or more years in college or in approved technical schools that include the prescribed courses in the sciences. The three years will be divided into a probationary term of four months, a junior year of eight months, and an intermediate and senior year of twelve months each. Vacations of one month each year will be granted. Hours of duty on the ward will be arranged with reference to the requirements of the class work. Throughout the probationary first four months they will not exceed six hours daily, and thereafter, eight hours.

Candidates should make application in person or writing, to the Surgeon-General, United States Public Health Service, Washington, D. C. Special consideration will be given to candidates who have taken the course in elementary hygiene and home care of the sick with the Red Cross, or who served as nurses and aides in army or civilian hospitals throughout the war. Candidates must be between twenty-one and thirty-five years of age, must pass satisfactory physical examination, and must be graduates of a recognized high school, or present evidence of an educational equivalent.

No tuition fee will be required. Students will be provided with quarters, subsistence, laundry and text books through the course. They must provide their own uniforms. A monthly allowance of thirty dollars for the first two years and fifty dollars for the third year to meet these and other school expenses will be made. Reasonable medical treatment will be supplied.

What right have we to the word civilized until we give mothers and children a proper chance?—John Galsworthy.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU GRAVES,
5618 Winthrop Avenue, Chicago, Ill.

THE DIETITIAN AS AN ASSET TO THE HOSPITAL*

BY RENA S. ECKMAN, HOUSE DIRECTOR, UNIVERSITY OF MICHIGAN HOSPITAL, ANN ARBOR, MICH.

TO THOSE who have been happily provided with a competent dietitian the title of this paper may seem a humorous one. To dietitians at large it may seem facetious. But to any one who has observed the activities of hospital dietitians over the length and breadth of the land, the question often arises, "What is the dietitian doing for the hospital that an untrained woman cannot do; and what is she not doing for the hospital which would be perfectly in keeping with her training and which would be of great benefit to the hospital?"

I once heard a superintendent of nurses in a large hospital make a few remarks on the subject. They were something like the following: "At first we wondered what to do with her. It seemed as if she might be an asset. But anon we also wondered if she were not also a liability. She seemed to possess knowledge that was a bit disconcerting to the buyer of food products; seemed to know things about food preparation that excited a longing inclination toward certain localities of the hospital and made discontent arise in other parts of it. She seemed to be somewhat like a cat in a strange environment, not very happy within the confines of her borders, inclined to be alternately frightened, entertained, amused, horrified or dismayed by the routine occurrences, professional, economical and social.

Dietitian Proves Her Worth

"But," the superintendent continued, "we found that after a certain amount of orientation had taken place, many conditions were so much improved that we could not think of going back to the time when there was no dietitian."

The dietitian finds many fields of usefulness open to her. In school lunch work where she has been sole manager of the food problem, her capability has been fully proved. Equipment, buying, handling of labor and technical supervision of cooked food products are phases of this vocation. Philadelphia, Rochester, Boston, New York and many other large cities have efficient school lunch systems. Many corporations, large department stores, banks and manufactories who employ large numbers of men and women have found it profitable to serve not only a noonday lunch but to care for the undernourished employee.

One banking institution in the City of New York operates such a plan. The dietitian of this bank told me that every known form of hospital diet, other than experimental, was represented in the daily output of her kitchen.

Now the evidence seems to show that the dietitian possesses certain capabilities or she would not be employed in organizations who manifestly cannot afford to run a lunch room or cafeteria at a loss. Miss Blanche Geary of the National Board, Y. W. C. A., New York City, recently said to the president of the American Dietetic Association: "Within six months we shall need fifty cafeteria managers. Within a year we shall need fifty more. We will pay these women from $1,500 to $3,000 per year, with food maintenance, often with full maintenance. You home economics people who conduct schools of practical arts must train these women for us."

Advised to Keep Away from Hospitals

Most organizations make the position of dietitian fairly attractive. We who are interested in having the hospital field covered, realizing what a great need there is for the various branches of dietetics in hospital work, are confronted by the attitude of technical schools and practical arts departments of colleges who have placed themselves on record as advising their students to keep away from hospitals. When interviewed on the subject the answer is, "Hospitals do not do their part in the training of the dietitian who is to specialize in hospital work."

If we analyze the conditions under which dietitians work we will find that a certain standardization is prevalent which applies to duties, hours and freedom of activities.

Should Be Trained in Accredited School

The application of these principles to the hospital field may be more or less difficult. But the modern trend of hospital management includes much talk of standardization. Hospitals on the accredited list must show that certain activities are present and are carried out with due precision. Accredited schools of nursing adopt certain standards of admission for the young women who would enter training and demand certain qualifications before allowing them to finish the course. Hence, in selecting a dietitian should she not be trained in an accredited school of theoretical and technical preparation? When suitably prepared the nature of the hospital field demands an internship of definite duration in an accredited practice field, before she should become an applicant for a position on the staff.

But let us return to the subject title of the paper. The

*Read at the Twenty-Third Annual Conference of the American Hospital Association, West Baden, Ind., Sept. 12-16, 1921

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administrative dietitian will have definite supervision of her department. The equipment there found, represents a vast amount of money. It is no small matter to have an intelligent watchful eye to inspect the operation and care of this machinery. The use and abuse of equipment should be controlled to the great advantage of the hospital. Picture for a fleeting moment what can happen to linen, dishes, silver, plumbing, power machinery, etc., without the application of intelligent principles of economy.

The care and inspection of food from its entrance into the hospital to the arrival at the service table is another tremendous item. Next to salaries, food cost is the largest figure in the budget of an institution. Unpopular food, poor quality either in the raw state or as a result of improper cooking, and unsuitable food preparations mean conspicuous waste. If poor quality food is bought it will be wasted not only in the process of preparation but also on the tables where it is served.

Schools Care For Undernourished Children

Other institutions than hospitals have found that it pays to care for their employees. The undernourished child in school lags behind his class. A mid-morning lunch is beneficial to his health, and improvement in his studies is not long in following. A little attention to the needs of poor nutrition, or the anemia of convalescence from minor ailments can increase the efficiency of the working force of the hospital far beyond the expense of providing for the same. That a suitable service room must be available for this purpose goes without saying. A diet laboratory is a work shop and should never be construed to be a catering or social center. Supplies may be issued from there but never consumed there.

The question of educational feeding of children within hospital walls demands consideration. A selected menu is only part of the problem. Both sick and convalescent children, yes, even adults, would be materially benefited if someone stood guard over the food presented to them, suggesting, recommending, coaxing, cajoling, and sometimes even commanding that food be eaten. I know of one university hospital where an assistant dietitian regularly seats herself at a long table where a number of convalescent children eat their meals. She makes it her business to see that the food is palatable, that the cooked or raw green vegetables are administered in some way to tempt the appetite, and that the soup is at least tasted several times as an education to the palate. Many times when a tray is put before a child he will attack the dessert, the popular dish, the white bread, or the food to which he has been accustomed and leave to wholesale waste the dish of spinach, string beans, or fruit sauce. Young children may not need roughage to stimulate peristalsis. But they do need to be taught to eat a variety of food, especially the iron bearing and anti-scorbutic fruits and vegetables. If training in proper food habits is not begun in childhood, far too many children will continue to swell the ranks of victims of deficiency diseases and subjects of low immunity to infections.

"Maximum of Dietetics," Says Dr. Dennett

Dr Dennett, in an address before the American Dietetic Association in 1921, said, "The modern trend in the care of children involves a maximum of dietetics with a minimum of medicine," and cited a record of one hundred cases of serious ailments in which fifty-four out of the whole number were cured solely by dietetics and hygiene. The importance of proper nursing care plus proper feeding is already not only recognized but is being more and more emphasized.

I know a mother who brought her little boy to the hospital with severe osteomyelitis of arms and legs. His little pale peaked face showed plainly a poor nutritive condition. Besides the nursing care he received, the dietitian visited him often and the nurses cooperated with her in forcing milk, fruit, and vegetables in the diet and forbidding absolutely the tea and coffee which he had been allowed to drink at home. He left the hospital four months later with an educated appetite and an educated mother. She promised the dietitian with pathetic emphasis that she would never allow her six-year old boy to drink coffee and tea again.

You say that it belongs to the business of nursing to administer food to patients. But what better could one do when thirty or more diets need supervision and only five or six nurses are available to serve, carry trays, and attend to all the things that never cease to come up even at meal time. Every little helps. The education of the pupil nurse is at stake as well as the care of the patient. The supervision of the food intake is one of the practical developments of nursing education.

What I am recommending for children has already been carried out in feeding helpless patients, especially typhoids. Many grown-ups are rather proud of their dislikes and tend to humor them rather than to modily them. Patients with finicky appetites should be urged to cooperate with the hospital who is trying to benefit them by giving intelligent but not whimsical attention to the food tray.

Many Duties For Dietitian

What should the institution require of a dietitian along practical lines other than the above? Why should not problems be studied similar to those that are scrutinized by an institution that feeds for profit? The life of a utensil, the amount of repairs necessary with various kinds of equipment, reports of phases of labor, census distribution in relation to cost per capita, allotment, routing, height and suitability of working spaces and surfaces must be thought of in planning new kitchens and in remodeling old ones. Sanitation if ever needed at all in a hospital is a keen necessity along the entire line of food preparation and service.

How much more intelligent demands could be made upon the food service budget if the dietitian could bring evidence of economic balance of menus. To illustrate: combine an expensive meat or vegetable with an inexpensive dessert, and vice versa. Conceal the matter from being too obvious by considering the popularity of the combination.

In reference to the more practical problems always present in the administrative dietetic field, it is opportune to say a few words. During the war we found it most desirable to replace man power in every possible way, by machinery, by condensing organization and by introducing cafeteria service. As yet we cannot find a surplus of desirable employees available. Most of the labor saving devices will be continued even when stability in labor has become less unusual. The central plant conserves labor and expense. To have a workable central plant is the problem to be considered if it is to be installed.

During the war we improvised and adapted to the last degree and obtained a great measure of success in operating a department with a short labor personnel. Now we must expand a little toward pre-war conditions but not forget the lessons we learned in conservation, and readapt them to the better operation of the plant.

Central dishwashing has been tried with a measure of success. With suitable conveyances, elevators and topographical situations it is practicable. The character of

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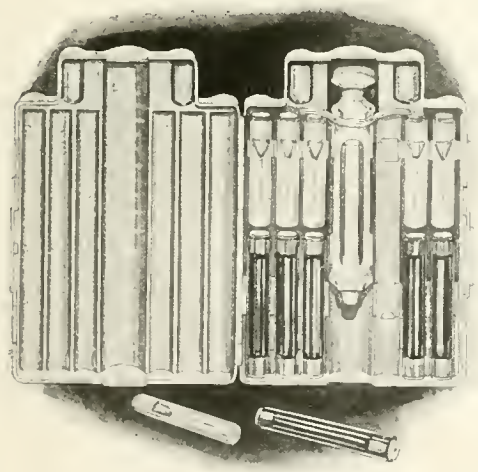

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dishes used may need to be modified. Distances should be studied with reference to time, labor and risk of breakage. Sources of contamination may be met with on the way to and from the dishwasher. Elevators may get out of order or traffic may be heavy and interfere with efficiency. The question of sterilization of dishes is more easily met in such a system than when hand power is used as in many different service rooms.

When more than one kitchen is operated many activities such as soup making, ice cream, cooking of fruit, vegetables and certain kinds of meat can be assigned advantageously to one of these kitchens and the products transferred to the others, as we have long since learned to do in transferring bread, rolls, cake, and baked desserts. More intensive study of the center as a qualitative producer will be necessary. An interested chief of the department is able to safeguard results to much better advantage.

Broth Good For Variety

While it has long been recognized that broth carries little nourishment we still find it useful for flavor, variety, stimulation, and for conveying liquid food into forced fluid diets. Plain broth or consommé may be made in large quantities, strained and left to jelly in an ice cold refrigerator. A protective covering of fat will seal it and it can be readily kept for a week or more. A more elastic menu can be served when facilities exist for keeping supplies on hand, and when brains and interest are coupled with the desire to work.

Fruit juices for liquid diets may be prepared in the central diet kitchen and dispensed either in bulk or as a bedside order. In our hospital we have various devices for making this up. In the late summer and fall fruit juices are most easily obtained. During the war we learned to can them as such and wait for the price of sugar to fall. Then they were used or dispensed as needed. Jelly could be made at any time. Fruit juice was ready for pudding or ice cream flavoring, for sherbet or other purposes.

Canned fruit is often made into pies or desserts, which do not require all of the juice. A dietitian I once met in the Middle West had a most clever way of mixing and flavoring collections of fruit juice and concentrating for ice cream sauces. The ice cream was always a delight for the flavor or the dip could be varied in so many ways.

Studies in the care of linen involve laundering and mending. We use paper napkins during the peach and pear season, placing a small package of them on each table when fruit is served in its natural condition. A suggestion in the shape of a conspicuous sign placed at the entrance to the dining room—"Kindly use paper napkins with the fruit. Thank you," and the family respond cordially. The laundry supervisor has been asked to refrain from bleaching each time the linen is washed and give one general bleach at the end of the offending fruit season. This procedure is less destructive to the fabric than bleaching every time stains appear. The stained linen is not a bad reminder to the family and helps them to realize the effect of their own thoughtlessness when fingers covered with fruit juice are wiped upon napkins.

Linen Inspected After Laundering

Linen should be inspected for wear each time it is laundered, and promptly mended. Worn tablecloths may be made into tray cloths and napkins. Dish towels should be darned and patched until they become too thin to hold together. Continual war should be waged against the use of dish towels and napkins for cleaning and polishing furniture and utensils. It is hard to believe that any hospital employee is so benighted that he or she would use a soiled guest napkin to wipe a clean plate, but such atrocities have been known to occur and sanitation in respect to methods of kitchen and serving room technic is by no means above reproach.

We require our ward dish washers to carry their soiled dish towels to a certain locality and hang them up to dry before throwing them into the laundry hamper. During the summer this precaution is most necessary. The same procedure is needed for kitchen aprons. Mould and mildew do not enhance the appearance of wearing apparel or even suggest cleanliness. As we use better methods of housekeeping we attract higher class workers to our force of employees. Wanton carelessness of hospital linen is not by any means confined to a single department.

Kitchen Utensils Washed in Special Sink

Kitchen utensils, in my opinion, should be washed in a moderately deep kitchen sink where there is not room enough to pile great numbers of them one upon the other for the purpose of soaking. A great weight of utensils damages those of the smaller sort. The operator in pulling this or that utensil around for this or that reason known only to himself, bends, twists, warps, wrenches off handles and damages even comparatively heavy tin, Russian iron, or agate containers. If the practice of long soaking in a vat of strong soap suds is used, all utensils are devoid of tin plate in a very few washings. A good chef will cooperate in protective therapy applied to his departmental furnishings. But I have had an old experienced man chef calmly assert to me that it did no harm to soak aluminum pudding moulds or other aluminum utensils in strong soap suds and that woman cook books were impracticable for large institutions. My reply to the former is, "Look at the dinges, indentations and small pittings in your aluminum utensils that have ben subjected repeatedly to a vat bath of hospital made soft soap." To the later, "Ask the family at large to compare the taste of institutional food where the number is over two hundred with that of the home product." In the former case how often can you find utensils clean to the touch? If standardized recipes are used, all of the art of the magician is needed to prevent the criticism—"Everything always tastes just the same." In defense of the kitchen I say, "How almost impossible it is to obtain from the commissary department the flavorings, garnishes, and niceties to secure attractiveness to the eye and palate." The spur of commercial aim is lacking in providing institutional dietaries. The buyer does not always realize his responsibility in this part of the institution's problems. Good quality of food must be bought or good results in dietaries cannot be obtained. Employees are prone to work, not for appreciation but to earn their wage with as little trouble as possible and to depart promptly at the end of an eight hour day.

Organized System of Criticism Helps

Organized systems of commendation and criticism are valuable aids in maintaining standards of cleanliness and good service, although therein also lie dangers. The high authority who deals out the criticism should realize the human attributes of even the humblest dishwasher. Often have I seen employees line up en masse, not willing to go off duty until they had heard the verdict rendered by the inspection committee. Their eyes shone with expectancy, hoping to hear "satisfactory"; crestfallen, shrinking demeanor showed how humiliating it was to them if some forgotten corner exposed lurking dirt. And if by toil and sweat they had scrubbed their tables to whiteness and their metal to shining luster and the dig-

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THE COMMODORE HOTEL
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nitary did not appear at the expected stated time to make inspection, groans and gestures of disappointment were evidenced with unction. Appreciation is dear to all. As a rule I have found that employees would rather he noticed adversely than ignored.

When food is sent to a ward in carts that are used to serve from, it is highly desirable for these carts to return to the kitchen to be cared for. Food is covered, of course, on its way to and from the ward. Left over food which is in suitable condition can be used. The noise of washing utensils is removed from the ward. The utensils return to the kitchen while the employees are still there and can be suitably put in order for the next meal service. Missing utensils can be checked up and much inconvenience avoided. It is also an economical labor problem, as one man or woman can wash up ten or a dozen carts and save the time of ward employees who are usually hired for this purpose.

New Problems Will Be Met

Dietitians have met and will continue to meet many kinds of housekeeping problems. In the many different types of institutions which hospitals present it must be expected that they will continue to meet problems which must be worked out on the hospital premises.

The majority of people, trained not too intensively in one direction retain the power of adaptability to new environment. It can be said with a large proportion of truth that adaptability or death has been the rôle of dietitians. That she can exceed the leopard in his power to change his spots has been proven in many instances. We find her combining duties of housekeeper, store keeper, buyer, and general manager with those of her own realm, and we predict that as new fields open up she will not only continue to be an asset to hospitals and cafeterias but also to increasing numbers of food industries.

CELEBRATION TO HAVE IMPORTANT FEATURES

The American Public Health Association announces four phases of its semi-centennial celebration to be held in New York City, November 8-18, 1921:

(a) *The Scientific Sessions* will be held November 14-18. There will be programs of the following sections: laboratory, vital statistics, public health administration, sanitary engineering, industrial hygiene, food and drugs. There will also be special programs on child hygiene and health education and publicity.

(b) *Health Institute*, November 8-12. During the week preceding the convention proper, there will be organized demonstrations of the various types of public health activity in New York and environs: health department bureaus, laboratories, health centers, clinics, hospitals, etc. The purpose will be to show health functions in actual operation, especially those which may be duplicated in other cities. In one sense the Health Institute may be considered as a school of instruction in practical health administration.

(c) *Dr. Stephen Smith*, the founder and first president of the Association, who is now in his ninety-ninth year, will be the guest of honor at a banquet to celebrate his approaching centennial and the semi-centennial of the Association.

(d) *A Historical Jubilee Volume*, "Fifty Years of Public Health," will be published about October 1. There will be articles by seventeen authors, relating to the accomplishments and present status of each of the important branches of public health. While concentrating upon the public health of the last fifty years, the book will describe the earlier beginnings of public health in an introductory way, and may, therefore, be considered a general history of public health from the earliest days to the present.

Detailed announcements, programs, and information concerning special railroad rates will appear in the

Dr. Stephen Smith, founder and first president of the American Public Health Association whose approaching centennial will be celebrated in connection with the fiftieth annual meeting of the American Public Health Association at New York City, November 8-18, 1921.

American Journal of Public Health and the *News Letter* of the Association from time to time, or may be had upon addressing the Association at 370 Seventh Avenue, New York City.

NATIONAL CANCER WEEK INCLUDES HOSPITALS

The American Society for the Control of Cancer has made elaborate plans for National Cancer Week, which is fixed for October 30 to November 5. Suggestions for organization, activities to be undertaken, and publicity have been sent to all local chairmen. Among the activities which are suggested are the following which are of especial interest to hospitals:

"The superintendent of no hospital should escape a visit from a representative of the Cancer Committee. They should be asked to devote at least three lectures on this subject to nurses during this campaign.

"The regular nurses' organizations should be included in the activities of this week. They might be asked to cooperate in the following ways:

"1. A meeting of their members should be held and the public health aspects of the cancer problem presented by a lecturer qualified in this respect, perhaps one connected with the department of health.

"2. Industrial welfare workers and nurses should also be reached in those cities where there are sufficient numbers to warrant a special lecture.

"3. A special meeting for Red Cross, visiting nurses and public health nurses might also be arranged either collectively or separately."

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Occupational Therapy and Rehabilitation

Conducted by HERBERT J. HALL, M.D., President, National Society for the Promotion of Occupational Therapy, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS. Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

SHOULD THERE BE SEPARATE O. T. SCHOOLS?*

THE Committee on Admissions and Positions elected by the National Society for the Promotion of Occupational Therapy formulated a long time ago an educative program which was never adopted as standard by the Society, but which has served as a basis for discussion.

The criticisms of this program have brought out a good many differences of opinion. The majority seem to agree with the subject matter as presented. A number of suggestions were made, however; for example, one person gives it as his opinion that the time allotted to weaving is too short, and that to metal work too long, while another thinks the exact opposite is the case. While these details will probably have to be settled separately for the different schools, it seems desirable that a minimum time for the several subjects should be designated in a standard course. The time allotment for the several subjects as well as the selection of the subject matter itself will depend largely upon whether or not the purpose in view is that of training the specialist in a few handcrafts or of giving the aide a short training in a number of crafts, trusting to experience in the hospital for further development of her craftsmanship. The latter arrangement may be more desirable as a way of meeting the shortage of aides, but it is apt to prove a rather hard and unprofitable experience for the hospital in the long run; still the general shortage of funds for the support of hospitals seems to make necessary the employment of the occupation aide who can turn her hand to many things. From my own experience, in which I have directed the practice teaching, in the hospital, of over two hundred aides, I have concluded that the employment of the aide who is well trained in a few handcrafts, rather than the one who has a little knowledge of a number, in the end proves the most satisfactory.

Advises Broad General Training

Again, the subject matter and the length of time for training will vary according to whether or not the purpose is to train specialists for the several subdivisions of the field, as determined by the character of the disability of the patient, viz., for work with the orthopedic, nervous and mental, tuberculous and cardiac, or general chronic case. In this, I would adhere to the well established principle of giving as broad and thorough a general training as possible before specialization is entered upon. I agree here, too, with Mr. Kidner's view, in that the training for work with mental cases should precede all other specialization in the therapeutic field. This will make psychology and mental hygiene important subjects in the curriculum.

One point has been brought in the criticisms which is certainly of greater importance today than either the exact choice of subject matter or the length of time given to the training, and that is the question of ways and means by which satisfactory training courses can be established and maintained.

This brings up for discussion the relative advantages and disadvantages between establishing separate schools for training occupational therapists, and incorporating training courses in the curriculums of the already established schools and colleges of the country.

My personal experience in planning and working out a training course in occupational therapy at Teachers College, Columbia University, has led me to understand the practical difficulties of introducing occupation courses into the curriculums of colleges. These difficulties will necessarily be present in introducing occupation courses into any already organized system, and especially so, as long as the numbers in training for occupational therapy are too small to allow of forming a separate unit. Also, we must have proof with which to convince college officials that there is sufficient demand for the college trained woman in this field, in order to justify the college in holding out inducements to her to enter it.

Difficult to Secure Necessary Publicity

Besides the difficulties met with in formulating a program suitable to the needs of the occupational therapy student from within the existing college curriculums, and the difficulty of getting the necessary additions to any curriculum for the occupation program, there is still the further difficulty of securing the publicity needed to establish a new profession. It is not the habit of colleges to advertise any one course in the curriculum, and yet proper advertisement and propaganda is a necessary factor in securing the numbers who will in turn be the means of acquiring the special features for a satisfactory course of training.

But, notwithstanding the practical and considerable difficulties in the way, I believe that the ultimate advantage of placing the training course in the already established educational institutions of the country is greater than in establishing separate and individual schools. On the point of economy alone much is to be said in favor of the former, as the cost of equipment, teaching staff, and overhead expense, it is evident, will then be at a minimum.

*Extracts from the address of Miss Susan C. Johnson, at the Annual Meeting of the N. S. P. O. T. September, 1920.

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Heretofore, and particularly during the war emergency period, we have drawn from the ranks of craftsmen and teachers for our personnel, converting these into occupation aides through short periods in the special training classes. In this, the special school served its purpose well. But, with the war emergency passed, and its sentiment and romance cooled into the stern and prosaic demands of everyday life, with the need of the civil hospital again receiving a normal share of interest, and with the great shortage of teachers, especially those in the division of industrial and applied arts, can we expect to continue to draw the needed numbers of occupational therapists from out of the ranks of these other professions? I think not. It seems probable that we shall have to look to training the young women from high school, and offering occupational therapy as a part of college or technical training.

If this new professional field which stands midway between nursing and teaching is to be built up soundly, expeditiously, and economically for the country at large, we must use as far as possible the established educational institutions. One has only to review the history of the training of nurses and of teachers to be reminded that the small, sporadic training school may supply a local need for some particular period but that its graduates have neither the prestige nor the broad education which is furnished by the older institutions of established merit.

There are many schools and colleges in our country which have already a major part of the required training for occupational therapists in their curriculums. It seems quite probable that a sufficient number of these could be induced to establish complete courses for occupational therapy and to make the alliance with hospitals which would be needed for the full training of the aide. These courses may not be just what we would choose in the beginning, but satisfactory results can be accomplished in time if we take what is already there as a beginning, and gradually shape and strengthen it into what is desired.

I know there exists a fear of the danger of our becoming too pedagogical if we affiliate with the regular school or college. I do not feel that this is a real danger, or to be dreaded. In fact, I believe that there is a definite need for sound pedagogical principles in the work of the occupation aide. If this training takes its proper relative place in a well balanced program, which includes at least three months of supervised hospital experience. I think we need not fear but what the "school teacher" attitude can be properly subordinated.

INDUSTRIAL ACCIDENT FIGURES

The writer keeps the following statistics on his desk, not too prominently, for they are a little depressing, but, among a lot of other papers, so that now and then he will come across the items and be reminded of some facts we might all of us like to forget, but which we must not be allowed to forget. Here they are approximately: 875,000 men and women disabled for more than four weeks annually; 76,000 people suffering loss of members; 200,000 otherwise permanently injured by industrial accidents; something like 250,000 permanently disabled each year by diseases incident to industrial employment. What an aggregate of suffering! How many helpless people! And they must all be cared for, restored as far as possible to health and self-support. Doctors, nurses, social service workers, physio and occupational aides, vocational teachers, these make up the personnel of rehabilitation, these are set off against the forces of industrial destruction. How well can the little army of reconstructionists succeed? Better than seems, at first thought, possible, if it is properly organized and directed.

More than race preservation is involved in the modern effort to restore the disabled, more than economic gain. The instincts of pity and the sense of fair dealing stand first perhaps in importance. When these qualities are aroused and we begin to work in the interest of the handicapped, the world becomes a better as well as a safer place to live in. Everyone who by his means or through personal service is helping on the business of rehabilitation may feel proud of his enrollment and glad of his opportunity.—EDITOR.

FLY MAKING

Have you ever tried fly-tying as an occupation in your hospital? It is a manly as well as a lucrative one. The bodies alone of some flies sell for fifty cents upward. And now that the lure of rod and tackle is in season, the project may be a promise of good times to come.

The art of fly-tying was introduced in Fort Sheridan last spring, by Emerson Hough, the author, and Mr. Fred Pete, a Chicago business man, whose hobby is fly making. First, they demonstrated to a group of aides how a "professor" was assembled on the hook. Later they started a number of ward patients on the new project. It was received with interest.

Bits of wool, chenille, tinsel, fur, yarn, feathers, quills, embroidery silk,—all sorts of odds and ends may be utilized in the construction of the alluring bait. The project is one that is certain to meet with the approval of the ward surgeon, and the aide will find her forceps a very necessary help in the creation of the fly.

GRACEFUL FOOTSTOOL MADE BY O. T. WORKER

Footstool made by Mrs. Guy Proctor of Somerville, Mass., formerly a pupil at Devereaux Mansion, Marblehead, Mass. The stool has a hand woven top, and mahogany body.

THE INDUSTRIAL CRIPPLE

Mr. Norman Dean, statistician, Ontario Workmen's Compensation Board, Toronto, Canada, says "It would require an army of over 43,000,000 men continuously in contact with the enemy for a year or of 4,000,000 for ten years to produce the number of industrial cripples unable to engage in their former occupations, alive at this instant in the United States alone."

Health is certainly more valuable than money; because it is by health that money is procured.—Johnson.

Adv. page 50

AMBULANCE

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Consult the 1920 Year Book for Catalog information.

Foreign Correspondence

BRITISH MEDICAL ASSOCIATION MEETS AT NEWCASTLE-ON-TYNE

ON FRIDAY, July 22, 1921, the final sectional meetings of the British Medical Association were held at Newcastle-on-Tyne. In the King's Hall of Armstrong College, a joint meeting of the sections of medical sociology and preventive medicine with industrial diseases, took place.

The subject for discussion was the situation of the British hospitals at the present time.

Sir George Newman, chief medical adviser of the Ministry of Health opened the discussion on "The Relation of the Medical Profession to Local Authorities in respect to the Rate-Provided Hospitals and Clinics." He said, in part, that at the present time there were two kinds of hospitals in Great Britain. The first group, consisting of general and special hospitals, were voluntary, and though in some degree state-aided were not rate-provided. They supplied something like 45,000 beds. The second group were non-voluntary and were rate-provided: they included poor-law hospitals and infectious disease hospitals and supplied 135,000 beds, excluding 18,000 sanatorium and hospital beds for tuberculosis. There were in addition, the institutions for the custodial care or treatment of lunatic and feeble-minded persons, which for convenience might be excluded from the present discussion, which numbered 128,000 beds. Thus already in England and Wales two-thirds of the hospital accommodation is rate-provided. Sir George proposed to put to himself three questions in regard to the subject. The first was "What did the local authorities require?" The local authority was recommended by certain ratepayers to discharge on behalf of the whole local community certain duties imposed upon it by Parliament or the ratepayer, and among those duties was the provision of certain medical services wholly or in part out of the rates. He suggested that in this matter the local authority required, or should require, an adequate medical service, which was regular, economical, and available to all ratepayers on certain specified conditions and terms; secondly, the selection of patients on grounds of urgency of physical needs, necessity for skilled medical, surgical, or nursing treatment, home circumstances and priority of application; and, thirdly, the payment by or on behalf of the patient for part, or all of the services required.

Obligation Not to Be Met by Whole-Time Service

The second question was "Could the local authority meet its obligations as regarded institutions by a whole-time medical service?" One thing was quite certain, namely, that a local authority could not meet its obligations without the aid of the medical profession. Should the liability be exclusively met by a whole-time service? He thought not. For while such a plan appeared to the authority to have substantial administrative advantages, it sacrificed, as a rule, certain guarantees of success, the goodwill of the medical practitioners of the area, the cooperation of the voluntary institutions and agencies of the area, and the partnership in working; above all, it sacrificed a substantial measure of local medical experience, and of freedom and mobility for the institution, for its staff, and for the medical profession in the area.

The speaker suggested that in rate-provided institutions the authority should give consideration to the practicability of the following means:

1. That representatives of medicine should be associated directly, by co-option or otherwise, with the public health committee or other governing body.
2. That there should be a medical staff committee for the medical administration of the institution.
3. That the services of general practitioners of the area should be obtained for the institution on the staff or otherwise; such an arrangement securing their interest and support, providing facilities for postgraduate study, benefiting the patients directly, and increasing cooperation between the consulting staff of the institution and the practitioners of the neighborhood.
4. That the medical staff, both consultant and practitioner, should be paid for their professional services, either by the authority or the patient, on a fixed basis mutually agreed between the authority and the staff, that the terms of office should be fixed; and that such part-time staff should recognize the suzerainty of any whole-time medical officer.
5. That there should be a local medical advisory committee, appointed by the medical profession in the district.

Medical Service "Casual, Confused and Wasteful"

Another paper contributed on the subject was by Councillor David Adams of Newcastle. He criticised the medical services of the country as casual, confused, and wasteful, and said that a unified medical service was imperatively required. In his opinion nothing better illustrated the need for unification and coordination in the hospital service than the fact that while municipal beds were in full occupancy, voluntary hospitals everywhere had waiting lists that could not be overtaken, in some cases for years, yet that poor law hospital beds were upon the average only half used. Additional hospitals were indeed urgently needed. In the language of Lord Cave,

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THE TRUTH ABOUT COFFEE

From a report of Prof. Samuel C. Prescott, head of the Department of Biology and Public Health, Massachusetts Institute of Technology

"Study of the literature of Coffee has revealed the unsatisfactory state of the knowledge in regard to Coffee, for aside from methods for the detection of adulteration (generally admixed substances) little had been done in a complete or thorough way. We found that practically every method which seemed likely to be of use had to be thoroughly tested and revised, that there were totally opposite opinions expressed on the same points and that hardly any two analysts agreed on any point connected with the chemical composition of Coffee, although unsubstantiated theories were plentiful.

"Since caffein is the most characteristic principle occurring in Coffee, is the source of its stimulating power, and is also the material which is most frequently suggested as an objectionable constituent, we made a thorough investigation to determine the best method of detecting and estimating this ingredient, and a thorough study of the actual knowledge of the effect of caffein on the normal body.

"A method has been established for the accurate estimation of caffein. This has been repeatedly tested and is entirely satisfactory for the comparative work projected and necessary for our purposes, *i. e.*, to determine the method of making the best beverage Coffee possible.

"The effect of caffein is known. For the great majority of normal individuals it is a mild stimulant of the heart, increases power to do muscular work, increases concentration of mental effort and therefore the power to do more brain work. It is not followed, except in excessive doses, by undesirable after-effects. A few people are especially sensitive to caffein, and for them its use is not to be recommended. In these cases the abnormality is in the individual rather than in any inherent poisonous or deleterious property of the caffein itself.

"Caffein can be taken by the vast majority of healthy adults without subsequent narcotic or depressant effect, provided it is used in moderation and not abused. Excessive amounts incite temporary disturbances in the central nervous system. It is equally true that other normally harmless substances, such as salt, sugar or condiments, may also produce untoward symptoms which are often severe.

"Our studies lead us to entire agreement with the results stated by Hollingworth that when taken with food in moderate amount, caffein is not in the least deleterious."

JOINT COFFEE TRADE PUBLICITY COMMITTEE
74 Wall Street, New York

"This country is hardly at the beginning of a real hospital system." In spite of the fact that voluntary contributions were larger now than in pre-war days, in spite of insistent organized appeals for assistance, the voluntary hospitals had been driven to solicit a government grant of £1,000,000 ($5,000,000) of which £500,000 ($2,500,000) had been promised for this year. Mr. Adams declared himself in favor of communal hospitals which for reasons of economy and general efficiency must continue under the administration of whole-time municipal officials appointed by and directly responsible to the local health authority. He also stated that in his opinion the actual clinical work of all hospitals should be divided up amongst the private practitioners and consultants if these were to secure the experience they now lacked. Yet there were vital obstacles to this procedure. The part-time official was more costly than the whole-time official. Would the necessity for the constant exercise of economy in municipal administration not rule out the clinical staffing alone by part-time persons of purely communal hospitals? The writer was convinced that it would.

Health Problems in a Tangle

Colonel Nathan Raw, M.D., M.P., said we must admit that at the present time, all the health problems of the country were in a tangle. We had had no great health scheme for some years. The first great constructive effort was the National Insurance Act. However, he felt sure that this would have to be amended in the near future, and he hoped that when this was done, it would be in the direction of providing institutional and hospital treatment for all the people under the scheme. Personally, he was opposed to a whole-time national medical service in Great Britain. It would not be conducive to the welfare of the people nor of the medical practitioner. It would only be a combination of the different methods for providing and maintaining health, state aid, rate aid and the contributions of the sufferers, that any universal system could be evolved. Colonel Raw thought that it could not be expected that the Treasury should subsidize voluntary hospitals. Perhaps the best way of solving the difficulty would be the payment by patients. In his judgment, any person who used a voluntary hospital ought to pay according to his means. When that was brought to pass, he felt sure that with a little help from the rates, or from some other source, the voluntary hospitals would be able to carry on a municipal scheme of hospitals combined with a voluntary scheme, which would be quite sufficient to meet demands.

Councillor Mrs. Mary Laverick said the working people of England were refusing to have charity or poor law assistance. The woman did not wish their children to have the "poor law taint" and they would rather die than see the children go into a poor law institution.

Waiting List a Sad Document, Says Mr. Orde

Mr. R. A. P. Orde, secretary of the Royal Victoria Infirmary, referred to the hospital waiting list as a sad document, and asked what the remedy for the waiting list was. Finance emphatically said "no" to the extension of existing hospitals or to the building of new ones. The patients on the waiting lists must be treated. In every hospital area there were many poor law institutions and hospitals with accommodation, much of it unutilized. To the ordinary man, the solution would seem obvious, to make use of these poor law beds; and that opinion would be confirmed if the ordinary man were to go round to these poor law hospitals and see the class of accommodations provided. He felt sure that if the general public realized what it was, it would never authorize a single penny to be spent on either extending the voluntary hospitals or building new ones, until it had satisfied itself that there was something in the nature of things, which made it impossible to utilize the poor law accommodation. There were the patients, the beds, and the doctors. What were the difficulties? First, according to his views, there was too much accommodation to choose from. If, for example, in the Newcastle area we were to require 200 beds to supplement the hospital beds, they could probably be found in a single poor law institution. Yet they could not send most of their waiting list patients there because they did not come from the area in which the poor law institution was situated. This was a difficulty which could be overcome. The second difficulty was that the patients were on the waiting list because they wished treatment at a particular hospital; but that could be got over by some simple affiliation between the general hospital and the poor law hospital selected to work in cooperation with it. The third difficulty was, of course, the "pauper taint," but appropriate separation of buildings would cause a great alteration of opinion which could be aided by affiliation with a voluntary hospital. If the approved societies could make grants to the voluntary hospitals it would be quite right and proper for them to make grants to poor law hospitals which were doing work supplementary to that of the general hospital.

Hospital Question One of Finance and Organization

The essence or gist of the suggestions put forward were contained in Sir George Newman's paper. These are the views of the Ministry of Health of which he may be termed the mouthpiece, in all that regards schemes calculated to promote the health of the community at large. However, in spite of the suggestions made at the meeting, it seemed that the solution of the hospital problem is by no means in sight. It is a question of finance and organization more than anything else, and up to the present both have been lacking. Colonel Nathan Raw spoke very much to the point when he said that the government was not likely to subsidize voluntary hospitals and he also expressed the opinions of many competent to judge when he suggested that perhaps the best way of solving the difficulty would be payment by patients. One might go further and state that the only means by which the voluntary system can be saved is by the aid of a graduated scale of payment by patients, always allowing a sufficient number of beds and proper treatment for those who are really unable to pay. In this wise the hospitals would be open to a large class of the population to whom up to the present they have been closed. Good medical and surgical treatment have been readily available for the rich and the poor, but those between these two classes have had to be content with very greatly inferior treatment. It is to be hoped that some workable scheme for placing hospitals on a sound basis will be decided upon soon, as it is becoming more and more evident that the existing unsatisfactory state of affairs cannot continue much longer.

NURSES' LAW PASSED IN MISSOURI

The Missouri legislature at its last session passed a new nurses' law, which became effective on June 20. According to this law, every person practicing nursing for money must be licensed by the nurse examining board, and a new division of nursing is created, called licensed attendants. The educational requirement for the latter class will be an eighth grade certificate. For registered nurses, however, after 1928, high school education will be required.

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544 Cap 201 Cuff

938 Gown
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1147
Gown

1981 Gown
20 Cap

23 Bib 511 Cap
224 Cuff

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(All sizes)
Long or short sleeves
1147 Indian Head or Twill, per doz..$17.50
Muslin, doz. .. 14.50

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(Sheeting)

	Doz.	Ea.
23	$4.75	50c
27	3.75	35c

Aprons

Sheeting, 72 inches

	Doz.	Ea.
Gathered	$15.00	1.75
Large gored	17.50	2.00

1760 Dress

Patients' Bed Gowns

(Three sizes)

Length 36, open, double yoke in front, tapes in back. Indian Head or Twill, per doz. $13.00
Muslin, doz.... 12.00

Collars and Cuffs

	Doz.	Ea.
272	$2.95	30c
274	2.95	30c
209	3.75	40c
201	3.00	30c
224	4.00	45c

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Perfectly Shaped NURSES' GARMENTS Carefully Tailored—Sizes 14-15-16

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Well Made NURSES' DRESSES—Chic

			Doz.	Ea.
Sizes 34 to 44	1700 Dress—White	Twill, Indian Head and Cambric	$45.00	$4.50
	" " "	Muslin and Colored Chambray	42.00	4.00
	1760 " "	Twill, Indian Head and Cambric	66.00	6.00
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PRICES SUBJECT TO CHANGE

QUERIES AND ANSWERS

NURSES SHOULD HAVE SINGLE ROOMS

To the Editor of THE MODERN HOSPITAL:

Should each nurse in training have a room to herself?
DIRECTOR OF TRAINING SCHOOL.

Yes, it is most desirable that each nurse in training should have a room to herself. Failing this, not more than two should occupy one room, due provision being made for proper space, air, light, and sitting room accommodations. The dormitory system of four, six or more beds, for instance, has been condemned by the best authorities.

TIME ALLOWED FOR ILLNESS

To the Editor of THE MODERN HOSPITAL:

What time should be allowed a nurse in training for illness? SUPERINTENDENT OF TRAINING SCHOOL.

Three weeks is the period most generally adopted.

SUPERINTENDENT OF NURSES HAS AUTHORITY IN DISCIPLINARY MATTERS

To the Editor of THE MODERN HOSPITAL:

Should the superintendent of nurses be the final authority in disciplinary matters and the consequences to be meted out? SUPERINTENDENT OF NURSES.

Yes, but it is deemed advisable to always consult with the superintendent or superior officer responsible for the hospital, and if there is no such person other than herself, she may confer with the member of the board to whom such matters are usually referred.

CLASSIFIED LIST OF FOODS

To the Editor of THE MODERN HOSPITAL:

Can you tell me of any book containing a classified list of foods?
A HOSPITAL DIETITIAN.

We know of no better list than that in Miss Fairfax Proudfit's book, "Dietetics for Nurses." This gives a classification of foods, according to liquids and soft diets, some for special diseases, and other classification according to carbohydrates, proteins, etc., also a number of recipes for these various classifications. This book is published by Macmillan & Co.

BOARD IS MORALLY RESPONSIBLE

To the Editor of THE MODERN HOSPITAL:

How far is the board of directors or trustees responsible for the kind of work done in the hospital?
MEMBER OF BOARD OF DIRECTORS.

The board of directors or trustees of any hospital is morally, though not legally, responsible to the public to see that each and every patient treated therein receives competent care so as to bring him back to health in the quickest and most comfortable manner possible. They must make sure that all the work carried on is efficient and that good results are being obtained. They are responsible to the public for supplying good accommodation, proper facilities and equipment, and above all, a competent personnel as the staff of the hospital. Usually the board of directors or trustees is spending public funds, therefore they have an obligation to fulfill, to see that such funds are spent in the best possible manner. Legally it may be said that in most jurisdictions, responsibility of a charitable hospital or its officers ends with the careful selection of employees, the employee being responsible for his own negligence or inattention. This does not apply to institutions not operated for profit.

REGISTERED NURSES PREFERRED

To the Editor of THE MODERN HOSPITAL:

Should our hospitals only engage and allow to nurse therein such nurses as have the R.N.?
SUPERINTENDENT.

Hospitals should only engage registered nurses, but in some places, as, for example, in British Columbia, under the present nurses' registration act, it is not compulsory that every graduate nurse be registered, and therefore they cannot be prevented from nursing in hospitals if they are properly qualified.

TWENTY-FOUR HOUR DUTY NOT TO BE ALLOWED

To the Editor of THE MODERN HOSPITAL:

Should twenty-four hour duty for special nurses be allowed in hospitals? DIRECTOR OF NURSES.

No, this requirement would be unfair both to the nurse and to the patient.

HOSPITALS SHOULD SUPPLY CERTAIN THINGS

To the Editor of THE MODERN HOSPITAL:

Should the hospital furnish the student nurse with uniforms, books, stationery and shoes, in addition to board, room, and laundry? SUPERINTENDENT OF HOSPITAL.

Many hospitals furnish uniform material, text, and note books, while others furnish only uniform material. It is generally agreed, however, that hospitals should supply uniform material, text and note books at least.

PROPORTION OF PATIENTS TO NURSES, ONE TO EVERY TWO AND A HALF

To the Editor of THE MODERN HOSPITAL:

What is a reasonable proportion of patients to each nurse in a general hospital, considering day and night separately, and different types of cases, such as private, semi-private, and public? BOARD OF MANAGERS.

One nurse to every two and a half or three patients is the generally accepted proportion. A distribution which works very well is as follows:

Day duty: One nurse to every five patients in a public ward. One nurse to every three patients in a private ward.

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XVII *November 1921* No. 5

RAISING THE STANDARDS OF PUBLIC TUBERCULOSIS SANATORIUMS IN ILLINOIS*

By GEORGE THOMAS PALMER, M.D., Springfield, Ill.

THE conditions surrounding public tuberculosis sanatoriums in Illinois are such that the elevation of the standards of these institutions requires unusual treatment. Until a very few years ago, Illinois had done less than any of the major states of the Union toward providing sanatorium treatment for her tuberculous people. There has never been a state sanatorium and the state government has never gone so far as to create a commission for the study of the tuberculosis problem, or the creation of a board for the standardization or control of institutions. As late as 1917 there were practically no public sanatoriums in Illinois outside of Cook County and the Chicago District.

During 1917, however, the Illinois Tuberculosis Association entered into active campaigns in a large number of counties under the provisions of the very excellent county tuberculosis sanatorium law. The result of these campaigns was exceedingly gratifying. Within a period of four years, about one-half of the hundred and two counties in the state had voted favorably on the proposition of establishing sanatoriums free to all persons, regardless of financial condition, and establishing free dispensaries and visiting nurse service.

What appeared to be a splendid victory for the state association soon threatened to become a distinct source of embarrassment. The county tuberculosis sanatorium boards in the various counties were, for the most part, made up of men and women who had not had the slightest experience in sanatorium construction, organization, or management, but, with the splendid enthusiasm created by the state association, many of the boards went boldly ahead making mistakes which threatened the future of the entire sanatorium program.

For the most part, the members of the sanatorium boards appeared to feel that the development of a sanatorium is a very simple matter, which can be safely entrusted to the local architect and contractor.

In Illinois, as in many other states, the chief relationship of the county government to medical matters, consists in the care and treatment of

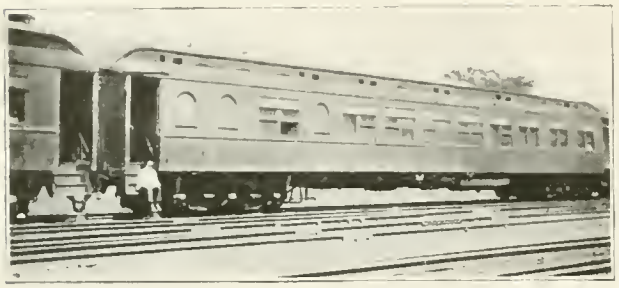
*Presented before the American Sanatorium Association, New York, June 12, 1921.

An "Illinois type" sanatorium.

paupers and destitute persons; and it was found very difficult to impress upon the sanatorium boards that, under the provisions of the law, the Illinois county sanatorium has nothing more to do with the pauper or indigent person than has the public school system of the state.

On account of the unfortunate exaggeration of the infectiousness and contagiousness of tuberculosis, it was found that the sanatorium boards regarded the county tuberculosis institution as somewhat akin to the isolation hospital or pest house, this sentiment being manifested in the selection of unfavorable and isolated locations and the consideration of pest house types of buildings.

While the state department of public health has certain limited jurisdiction over county and municipal hospitals, its authority extends only to the



One of the three cottages on wheels in which the Pilgrims traveled.

point of inspecting and recommending changes or improvements, but there is no penalty imposed upon the sanatorium board for ignoring the recommendation of the state department of public health, nor has the department any specific power to dictate or direct methods of diagnosis, treatment, or institutional operation. Under its general powers, of course, the state department of public health can assume supervision of the tuberculosis sanatorium on the ground that it is a place for the isolation of persons suffering from communicable diseases; but this could not be successfully done unless the violation of precautionary measures were flagrant and the institutional management exceedingly bad. In other words, there is no constituted authority in the state of Illinois legally authorized to pass upon the standards of tuberculosis sanatoriums.

In view of the mistakes that had been made in the sanatoriums already established and in view of the large number of institutions to be established within the next few years, it became imperative that something be done and the state department of public health and the Illinois Tuberculosis Association undertook the inspection and rating of existing sanatoriums, utilizing the limited authority given to the department of health. By exercising the utmost tact and diplomacy in carrying out the program, but one institution of the twelve in operation offered objection to the inspection; all of the others placing at the disposal of the inspectors every possible facility, and acting promptly on all recommendations made.

We were able to secure the services of Dr. W. H. Watterson, who is now connected with the United States Public Health Service, and who has had perhaps a more varied experience in the operation of sanatoriums, both large and small, public and private, than any other man in the Middle West. In making the inspection, Dr. Watterson employed the scheme of rating adopted by the American Sanatorium Association* with certain minor modifications deemed advisable in view of the provisions of the Illinois sanatorium law, and it was definitely understood that the first ratings would not be made public, but would be used for the guidance of the sanatorium boards in bringing about desirable changes and reforms. It was made clear to the sanatorium boards, however, that subsequent inspections would be made and that the results of all later ratings would be widely published for the guidance of the medical profession and the public.

The policy was pursued of allowing additional credit for exceptional features in institutional operation not ordinarily expected in sanatoriums of that particular size and type and the practice was followed, in rating all institutions, to give no credit for unused or misused equipment, but rather to place the accent upon the character of professional service.

Use of Equipment Counted

For example, an elaborate and expensive x-ray equipment entitled the institution to very little credit unless it was demostrated that the methods of employment were technically correct and the medical staff capable of intelligent interpretation of their findings. The intelligent employment of artificial pneumothorax entitled the sanatorium to special credit, but if it was found that artificial pneumothorax was used excessively or unwisely, deductions were made on that account.

Inasmuch as the results of the ratings were frankly submitted in detail to the members of the sanatorium board and the medical staff, it became a source of considerable embarrassment to fairly rate the efficiency and intelligence of these persons. This however, was performed by Dr. Watterson with the utmost tact and with the development of little or no friction. In one instance he announced to the members of the sanatorium board that he had rated the board as 50 per cent

*The sanatorium score card of the American Sanatorium Association, based upon 100 points, allows 3 points for location and site; 5 points for plant and equipment; 18 points for institutional administration, and 74 points for medical and nursing service.

efficient on the ground that, of the three members constituting the board one had been absent from every meeting; while another had failed to attend half the meetings. Assuming 100 per cent efficiency and fitness on the part of each member of the board, Dr. Watterson successfully contended that an absent member is a 100 per cent useless and inefficient member.

Of the ten institutions inspected, one was rated as a class "A" sanatorium with a rating between ninety and ninety-five points; four were rated as class "B" institutions with a grade of from eighty to eighty-nine and nine-tenths points; while five were regarded as unworthy of classification. One rated as low as forty-eight points and another forty-nine points.

Sites Usually Satisfactory

For the most part, sites, locations, and buildings were reasonably satisfactory, the large deductions being made on account of the inferior character of medical service.

A number of months have elapsed since the making of these inspections and it is now safe to say that this one inspection has accomplished a great deal in the elevation of standards of all Illinois public sanatoriums. It was found that the more serious faults in institutional operation were due to a lack of knowledge on the part of sanatorium boards, and that these organizations were receptive of constructive advice and criticism. This was found true in driving home the one idea that every sanatorium must have a full-time specially trained medical director. The inspections served to distinctly improve the med-

Just some of the Pilgrims.

ical service of existing institutions and to pave the way for better conditions in the future.

It is to be hoped that the state department of public health, whose personnel has been materially changed by political conditions, will see the wisdom of making supplemental inspections and re-ratings. This is particularly desirable in Illinois where, according to the interpretation of the attorney general, the law provides that it is not necessary for a county adopting the county sanatorium proposition to actually erect and maintain a sanatorium. At its discretion the sanatorium boards of smaller counties may employ the funds raised by the special sanatorium tax in placing tuberculous patients in institutions in other counties.* The frequent re-rating of sanatoriums will not only afford reliable information to sanatorium boards in selecting the institutions in which their charges are to be placed, but will cause an elevation of standards among all county sanatoriums seeking patronage from other counties.

Intensive Educational Campaign Imperative

While the inspection and rating of existing sanatoriums have done much to improve the few institutions now in existence, they could have little influence upon the very large number of sanatoriums to be established within the next few years. To avoid the serious mistakes already being made and to stimulate intelligent action on the part of county sanatorium boards that had remained entirely inactive, a campaign of intensive education became imperative. It was impossible for the Illinois Tuberculosis Association to send competent representatives into the fifty counties having sanatoriums in contemplation, to remain long enough to win the confidence of the members of sanatorium boards and to exercise any great degree of influence. It was consequently decided to invite the members of all the sanatorium boards, together with members of boards of supervisors and county commissioners, with physicians, nurses, and other interested persons, to go on a personally conducted tour of inspection to a group of public and private sanatoriums in Illinois.

The response to this invitation was astonishing. Three Pullman cars were comfortably filled and the journey was made to eleven different institutions, occupying a full week.

Attached to the train was a large baggage car whose walls were covered with exhibits, sanatorium plans, and educational material, and this car was used as a class-room on wheels by a staff of experts in every phase of tuberculosis work. The staff included clinicians, architects, sanitary engineers, institutional nurses, institutional managers, and visiting nurses.

At each town that was visited one or two large public meetings were held under the auspices of the local tuberculosis association and the county medical society and at these meetings the members of the teaching staff gave addresses on dif-

*The uniting of counties to create district sanatoriums is unconstitutional in Illinois.

The Pilgrims of the Ottawa Colony.

ferent phases of tuberculosis work, all of these lectures being so arranged that they constituted a connected course of instruction on some thirty different subjects.

On visiting the sanatoriums, the party was divided into groups and each group was personally conducted by some one competent to intelligently criticize the institution. Then at informal meetings held in the sanatoriums, the architect, the medical director and the head nurse were requested to state the desirable features and the definite mistakes that had been made.

The number of persons taking part in this pilgrimage averaged about seventy throughout the trip; the number occasionally increasing to over a hundred. It is believed that fully two hundred and fifty persons accompanied the party at one time or another, while fifty-five completed the entire itinerary.

Great Enthusiasm Shown

In all of my experience, covering ten years in public tuberculosis work, I have never known an educational enterprise in which such keen enthusiasm and interest were manifested, nor one so directly productive of salutary results. The pilgrimage ended on May 14, and the following month there were inaugurated numerous constructive activities in many counties of the state where distinct apathy had hitherto prevailed.

In one county, where the sanatorium is not yet constructed and where it appeared to be the impression that the county sanatorium was merely a question of brick and stone and mortar, a plan has been approved for the establishment of a central dispensary under competent direction and a chain of local clinics in every sizable community.

One municipal official who manifested the utmost indifference on the first day of the pilgrimage and who expressed his intention of returning home the following day, accompanied the party throughout the week and left with the declaration that his community would immediately establish open air schools and nutrition classes as a part of the definite Illinois county sanatorium program.

Aside from the first-hand information received by the members of sanatorium boards and conveyed to them by practical demonstration rather than by word of mouth, the eleven institutions visited were tremendously helped by the frank criticisms of the pilgrims and of the experts who accompanied them, while in every community the visit of the pilgrims gave tremendous impetus to the work being carried out by the local sanatorium boards and the local tuberculosis associations.

Attitude Changed During Pilgrimage

With the idea firmly implanted in their minds that a tuberculosis sanatorium is merely a building which can be designed by any man claiming to be an architect, and directed by any man possessing a license to practice medicine; impressed with the notion that a county sanatorium is something of a pauper institution and closely akin to the pest house, it was tremendously interesting to see the development of opinion and the change in attitude which came over these men and women as the days of the pilgrimage passed. All of them returned to their homes satisfied that medical and nursing service are infinitely more important than buildings and equipment; all of them were convinced that tuberculosis dispensaries and visiting nurse service must precede the sanatorium; all of them were satisfied that open air schools, nutrition classes, and child welfare activities are a distinct part of the program of the county sanatorium. It is my profound conviction that the Illinois Sanatorium Pilgrimage will extend its influence in the elevation of standards of institutional care in the state for many years to come.

Saw Limits of Score Card Rating

Incidentally, the pilgrims who had fully been advised as to the score card method of rating institutions, had an opportunity to see the limits of usefulness of the inspection and rating of public institutions. It was realized very definitely that there is no way by which one may reliably rate that exceedingly important, but intangible thing, the personality of an institution, and it was observed by the pilgrims that some of those institutions which were graded highest in the inspections made by Dr. Watterson failed to compare favorably with those less satisfactorily rated on account of the unfortunate personality or misguided point of view of an otherwise thoroughly competent and efficient personnel.

HOSPITAL ADMINISTRATION AND THE TRAINING SCHOOL; HOW THEY AFFECT EACH OTHER

By A. K. HAYWOOD, M.D., Superintendent, The Montreal General Hospital, Montreal, Canada

It has been increasingly evident with the development of the hospital that the administration of the hospital and the training school are closely related, and that in many ways they react upon each other. The superintendent of a few years ago did not understand or enter into the problems of the training school. He must do this today if the hospital is to function as a perfect whole. The training school is perhaps the most important department of what is really a business organization—the modern hospital. As in a business organization the department heads must be taken into the confidence of the administrator and must also take him into their confidence if the final result is to be attained.

THERE was a time when such a title as the above would have seemed to me an opportunity to take the nursing profession to task or to air many so-called grievances against training schools. But that was many years ago, when I was beginning to learn hospital administration. At that time I was willing to pit my enthusiasm against the knowledge of training school superintendents who were exceedingly wise in their particular profession. Time has demonstrated to me most emphatically that hospital administration and training school administration cannot be separated as oil and water, but have a common interest that must be directed by both sides to the glory of the hospital as a whole.

It is not so many years ago, that the matrons of the training schools of our large hospitals were monarchs of all they surveyed, and rightly so; hospital superintendents had not learned their share of the mysteries, troubles, and joys of the matron of a training school. In many cases, the superintendent of the hospital was a layman who had grown up with the hospital, but who could never grow up with the training school, because they spoke different languages. These men were excellent business administrators, but it inevitably meant that to a large degree the training schools were forced to work out their own salvation.

Changes in Hospital Administration

The administration of a general hospital fifteen or even ten years ago, was quite a different problem from the complex situation that presents itself under that heading today. During the last decade our hospitals have been compelled to undergo many radical changes. I refer in particular to questions of policy and finances, and in each of these broad principles, the training school has a very definite relation to the administrative head.

The modern hospital administrator has done well to pattern his business (that of hospital management) after that of our large corporations. The old, careless, happy-go-lucky methods of conducting our charitable institutions in the past have given way to modern business methods. We look upon our hospitals today as large factories; our product is not boots and shoes, but health. We have our various departments all contributing to the manufacture of that product, and not the least important, if not the most important department, is the training school. If these departments are to be asked to contribute their quota to the end that our product, health, may be the finished article, they must be taken into the confidence of the administrator, share his successes and troubles. On the other hand, it stands to reason that if the administrator is to be more than the nominal head of his institution, he must in turn study training school problems in general, and the problem of his own training school in particular.

Clerical Work Given to Training School

One very serious effect that modern hospital administration has had upon the training school is the large amount of clerical, or work of a purely business nature that has been placed upon it and by it distributed to the ward directresses, and in turn by them to the undergraduate nurse. A sympathetic administrator can accomplish much by education in securing this business assistance from his training school head. I mean by that, tactful consideration of the troubles and inconveniences that this work will entail. Training school heads are, as a body, reasonable people, and can be shown whereby these improved business methods are both necessary and beneficial for their hospital. Although it is very difficult at times, and impossible at others, to prove that any direct benefit will accrue to the training school, there is no doubt that there will be indirect benefit in direct ratio to the general im-

provement in the hospital. The policy of not letting your right hand know what your left hand is doing, has been tried in hospital administration and has failed miserably. If the matron of your training school is to be expected to instill into her nurses, the spirit of cooperation, so essential between the various departments in a hospital, it is necessary that she be as well informed as possible, of the problems of those other departments. This is being accomplished in several of our larger hospitals by regular meetings of the different department heads. At these meetings each one learns something of the difficulties of the other, and it is here that one looks for original suggestions for the betterment of the hospital as a whole. It would be unjust to the head of the training school to place her upon an equal footing with, say the head of the laundry, the housekeeper, or the heads of any of the other subdepartments at these meetings. However, one should endeavor to make the staff meetings as democratic as possible, always guarding against the personal element which is so liable to creep in between heads of departments whose feelings have been hurt, or whose authority has been encroached upon. At the same time the dignity and importance of the training school should be impressed upon all in order that they, in turn, may carry into their departments and to their employees, be they mechanics, servants or clerks, the proper sense of courtesy and deference which our training schools have earned in their development from the day of "Sarry Gamps" to the, may we say, finished product of today?

New Subjects Added to Curriculum

The modern hospital has added many departments to its organization of recent years. This has been made necessary in order to cope with the advances made in medicine. We have hydrotherapy, physiotherapy, metabolism, social service departments, and a host of others in addition to special clinics, such as nutritional clinics for children, child welfare, diabetic, fracture, and venereal disease. These are all necessary in modern healing, but they have made serious inroads into the training school. There are very few hospitals that have not been compelled to increase their proportion of nurses to patients, to keep pace with these modern methods. Here we have one very good reason for the shortage of nurses that seems to exist at the present time. The establishment of so many of these departments by our hospitals has necessitated in turn a serious increase in the instruction given to an undergraduate nurse, until at the present time we have training school matrons wondering how on earth they can get time to add this or that new subject to their curriculum. One cannot resist sounding a note of warning to guard against our nursing curriculum becoming too much theory and too little practice. One hears so often nowadays that the present day nurse does not compare favorably with her predecessors of ten years ago. I do not agree with this, but I feel that modern hospital administration does seriously affect the training school by the addition of these new departments which we are so frequently adding to our organizations.

Poor School Usually Means Poor Hospital

I cannot help feeling that the hospital administrator of recent years has exerted a considerable influence over the destiny of the training school of his particular hospital. We know that there are good schools and poor schools, but we also know that it is seldom that one finds a poor training school without finding that the rest of that particular hospital is considerably below standard. A good training school can exist in a poor hospital, but its existence will be of short duration. It can exist only by the almost superhuman efforts of an excellent matron. There are a hundred and one petty troubles that confront the matron daily, but in my opinion, many of these troubles can be partially solved or shouldered by the administrative head of the hospital. If the matron has the confidence and respect of the superintendent, and vice versa, I feel convinced that the effect of hospital administration on the training school will not only be beneficial but pleasant.

Let us look for a few moments at the other side of my subject—the effect of the training school on hospital administration. The points which I have tried to make regarding the placing of so much clerical work on the training school were for the purpose of showing the effects of the administration on the training school. On the other hand the ability or inability of the training school to carry out this work, has a still more serious effect on the administration of the hospital. Local conditions will in many cases govern in the community. At the Montreal General Hospital we call upon the training school for assistance in many ways. We have a system of keeping our patients' accounts which calls for daily reports from departments such as operating rooms, surgical supply office, etc., all of which are prepared by the nursing staff. These are not always correct, but lest I be misunderstood, I must state that every endeavor is made by the training school to have them rendered promptly and correctly. The listing of patients' clothes and valuables, the requisitioning of supplies, or requests for repairs —all clerical work at present done by the members

of the training school, brings the training school into intimate contact with the administration of the hospital. It naturally stands to reason that the administration of an institution which employs these methods will be more or less at the mercy of the training school. Nurses in training and even graduates in charge of wards must have a working knowledge of the administrative methods with which they are being asked to assist. Unfortunately for the administrative side of the hospital, the constant changing of the personnel of the training school causes many breakdowns in the assistance they are asked to render.

Nurses Need Some Administrative Training

One hears so often the criticism that the nurses are for nursing only, and their services should not be commandeered for administrative purposes. I can assure you that with the present shortage of applicants for training schools in North America today, he would be a very short-sighted superintendent who would impose upon the training school any work apart from nursing, that was not necessary. Yet, on the other hand, many of your present undergraduates are some day going to be the future training school heads, and it is vital to them that at least a small working knowledge of these problems be obtained while in training.

Hospital administration is not a sinecure. Medical men have not yet realized the future of this branch of work. It must not be looked upon as a position to be occupied by medical men who, having failed in private practice, enter this branch in order to eke out a living with the least amount of effort. That has happened before, and that is one of the main reasons why it is so difficult to secure medical men as assistants. If this continues it will not be improbable that our large hospitals will have at least one assistant superintendent, a trained nurse, and probably more. I cannot help feeling that this arrangement would bring to the administration of the hospital many advantages and make for a still closer cooperation between the training school and purely administrative departments.

Eight Hour Day Entails Many Changes

The movement that is slowly but surely spreading over this continent for an eight hour day for nurses in training, has undoubtedly given many a hospital superintendent much cause for worry. I think I am safe in stating that the policy of an eight hour day is now generally accepted as reasonable and fair. There are still many of our large hospitals that have not adopted it, not from any lack of desire on their part, but because of the demands that this change would make on their annual budget, and available accommodation. It means in many cases new quarters being erected for the additional nurses required, and a considerable increase in the pay-roll in hospitals where undergraduates are paid a monthly or annual honorarium, to say nothing of the additional expenses which this increase in the nursing staff adds to practically every department. The superintendent that has to face this change to an eight hour day, realizes only too well, if his accommodation is limited, that this is one of the training school problems that it is going to have a most serious effect on hospital administration. Coupled with this is the general movement in all our large hospitals for a betterment of general living and social conditions for our nurses in training. The modern young women that come to our training schools are not going to stand the semi-slavery conditions that have existed in so many places in the past. They demand that justice be tempered with mercy, that in being called upon to do a grown woman's duties, they be treated as women —that opportunities be provided, within reason, for recreation and social life. These problems are dealt with by so-called training school committees in many hospitals, but the training school problem is becoming one of such magnitude that our hospitals are gradually employing administrators who will study the problems of this department as they would any other department of the hospital.

School a Professional Institution

Not all of the effects of the training school on hospital administration are either pleasant or beneficial. Traditions have instilled into our training schools a well earned and well merited feeling of superiority. There is no doubt that in a properly governed school the discipline among the nurses will be superior to that of many of the other departments of the hospital. In addition to this commendable asset the training school is a professional institution and rightly demands professional respect. It is these various attributes that contribute every now and then to some of the worries and pleasures of the administrative head. I do not think that hospital employees are thin skinned but it is a remarkable fact how frequently one is called upon to settle some misunderstanding between some member of the training school and the housekeeper, engineer, foreman, dietitian, or steward. My experience has taught me that in the main the training school is correct, but some of the judgments that the administrative head is asked to render would seem to require not only all of the wisdom possessed by Solomon, but also the patience of Job.

THE BROOKLYN DIAGNOSTIC INSTITUTE

By JACOB GUTMAN, M.D., Phar.D., F.A.C.P., Brooklyn, N. Y.

AS A natural consequence of the growing appreciation of the advantages of the collaborative study, or group diagnosis, of disease, those who have played a part in its development are frequently called on for such suggestions as may prove helpful to others in extending the facilities for the prosecution of this branch of medical service.

As founder of the Brooklyn Diagnostic Institute, the first of any magnitude to be established in the East, it has been my lot to receive a great many inquiries relative to the organization and conduct of diagnostic institutions, and also to become acquainted with the obstacles encountered by those who take the initiative in placing these at the service of the clinician.

Reception Room

It is thus the design of this paper to import such information as may prove conducive to a better understanding of the precise functions of a properly conducted diagnostic institution and to serve as a reply to the numerous inquiries received from many sources. By limiting myself to the citation of a specific example and only describing the organization, scope, and other vital issues of an institution already established and in full operation, the Brooklyn Diagnostic Institute, I hope to avoid immaterial discussion, and indulgence in generalities.

In a previous article[1] the advantages and superiority of group diagnosis have already been discussed and will not be dwelt upon in this presentation.

The resolution to establish a group diagnostic institution originated with the writer in 1908. Inspired by the wonderful achievements in diagnosis at several sterling medical centers in the Western states, he decided to establish a similar institution in his own locality, the state of New York. Realizing that no cooperative organization of specialists, even of the highest type, is in a position to offer the best of services and guarantee success without the interpretation of the conclusions by an experienced, broad-minded and competent internist, for "after all, there is no use in a lot of data brought together by a group of men unless there is some one individual able to sum up the information accumulated by the group," the founder decided to enrich his diagnostic skill by postgraduate studies abroad. At the University of Vienna, with Eppinger, Biedl, Van Noorden, Singer, Frankel-Hochwart, and other eminent diagnosticians, so as to prepare himself fully for his part of the work, before proceeding to the actual organization of the proposed institution. Having supplemented his work abroad with a study of various hospitals and institutions, he laid the foundation of the present establishment in the borough of Brooklyn. The decision to organize the institution in this borough was based on the fact that this residential part of greater New York has not, as was the case with the borough of Manhattan, already become the homes of scores of commercial diagnostic laboratories.

During the first few years of its history, the quarters of the Institute were small and devoted

Library

1. Gutman, J., Group Diagnosis, Med. Record, May 15, 1920.

entirely to laboratories, patients being sent for examination to the offices of the different members of the staff. In due course, another very much larger building has been acquired, and altered to accommodate a number of specialists' departments, fitted with all requirements to facilitate their work. Thus, at last, all attributes of a modern group clinic had been instituted, provision having been made for the examination of patients under one roof, by capable specialists in an expeditious and practical manner.

Bacteriological laboratory.

The Institute is now located in a most exclusive but easily accessible residential section of the city. It occupies the entire five-story building, with a floor space of about ten thousand square feet. It provides abundant space for the heads of the departments. The first floor is devoted to the serological, microscopical, chemical, and bacteriological laboratories, x-ray, and dark rooms. The main floor is occupied by the director's office, reception rooms, and the medical department. On the next floor are located the library, cardiological, ophthalmological, cystoscopic, and gynecological departments. The entire floor above is devoted to physiotherapy, gymnasium, electrotherapy, Zander treatment, baths, and thermotherapy. The top floor is utilized for rest rooms and solarium.

Medical department.

The equipment of every department is most complete and comprises every scientific instrument in use—electrocardiograph, polygraphs, metabolism apparatus, colorimeters, polariscopes, every conceivable apparatus required for x-ray diagnosis, cystoscopy, ophthalmoscopy, proctoscopy, clinical chemistry, etc. The library contains several thousand volumes, and all the leading periodicals devoted to the different branches of science.

Consultation room.

The staff of the Institute is made up of sixteen clinical directors, assisted by the highest type of laboratory technicians and associates. A limited number of associates are appointed each year to the Institute. Active practitioners in good professional standing are eligible to such appointments. Associates to the Institute are privileged to assist in its regular research work, to present and discuss papers, to receive diagnostic service for themselves and their immediate families, and to be compensated for service rendered by special arrangement, on a cooperative basis.

The scientific administration of the department is vested in the clinical directors; the executive function in the director of the Institute. None of the members of the staff are burdened

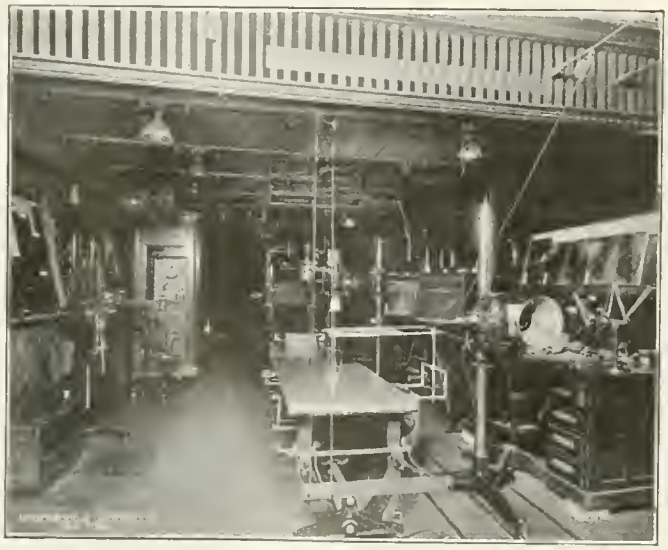
Chemical laboratory.

with any financial responsibility; all capital obligations and responsibilities are assumed by the founder of the Institute. The clinical directors receive ample compensation for their services, independently of the institution's income; the associate members are remunerated for their services by sharing cooperatively in a fund derived from the excess income of the Institute. It is aimed to have the institution self-supporting and independent of private donations, contributions, or endowments, upon which most other organizations depend. Neither is it purely for gain, hence the fees for services are arranged with this point in view and are only sufficient to sustain the institution and provide for the proper compensation of its staff and employees and normal expansion.

Staff meetings are frequent, in order that the collective findings of the directors of the different departments may be had in any case referred to the department. Lectures are given by the directors of the various departments, to which members of the medical profession are always welcome.

Every general case is subjected to a classical examination which includes a morphological study (pathological), an examination of the excretions (chemical), and functional tests (endocrine); in short, a determination of the precise nature and degree of every structural and functional deviation from normal. The individual findings of the various members of the staff are referred to the internist, who, after taking into consideration the history and all other data, prepares the conclusions and such suggestions as are deemed appropriate. "Successful practice is never possible unless the patient is considered as a whole, with a mind and body, rather than what is in effect regarding him as a bundle of associated organs; therefore, the head of the diagnostic clinic has to possess certain qualities, which, it seems to us, are very closely related if not identical with those developed by the first class general practitioner in the course of his own practice."[2]

Serological laboratory.



Roentgenologic department.

The cardinal principles of the Institute are:

1. To hold at the command of the general practitioner the highest type of diagnostic skill.
2. To be scrupulously observant of the loftiest standards of professional ethics.
3. To perpetuate the identity of the patient, whom the clinician refers for examination.
4. To give no information to patients under observation, but to embody the results of every investigation in a report to the physician of record.
5. To offer no therapeutic suggestions unless requested by the referring physician.

2. Editorial, MODERN MEDICINE, November, 1920.

6. To permit the physician of record to take part, if he desires, in the study of a case.

7. To permit the clinician to assist members of the staff in research work.

8. To give the clinician the option of referring a case to any single department or for any analysis, but in the absence of specific instruction, to have the staff determine the extent of all examinations.

To provide for the indigent class, unable to avail themselves of the Institute's facilities at the regular fees, one day a week has been assigned when services of the staff may be had as on other days, for a nominal charge.

All such cases are subdivided into four classes, gastro-intestinal, pulmonary, cardiac, and renal, and are treated accordingly.

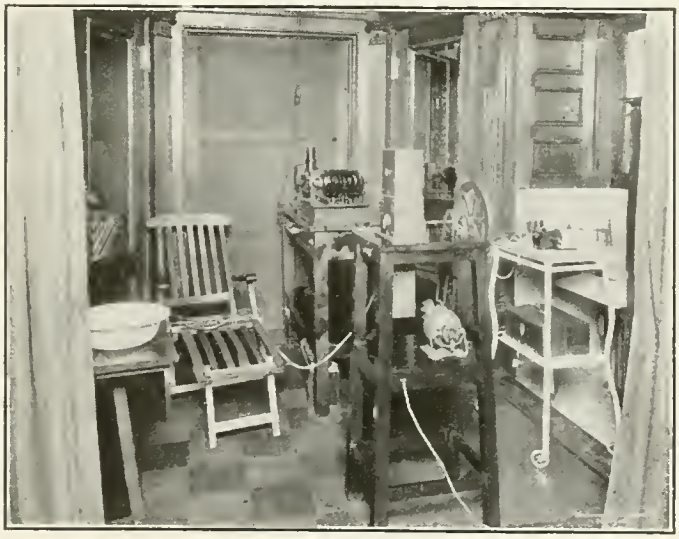
To fulfill the needs of local internists, who understand the necessity and incalculable value of physical therapy in the alleviation of chronic disease, this institution has added to its diagnostic facilities a department of physiotherapy. Whereas, the care of surgical and acute medical cases is amply provided for by the existing hospitals and sanatoriums, the treatment of chronic ambulant cases is sadly neglected because of the lack of physiotherapeutic facilities, indispensable in the care of these cases. Such neglect prompts the chronic sufferer to seek the aid of "irregulars" whose therapy is essentially physical, and, not infrequently, unscientifically applied, and to abandon the regular practitioner. To obviate such a state and remedy this defect, the Brooklyn Diagnostic Institute has established a department of physiotherapy, equipped with every known modern appliance (Zander apparatus, gymnasium, electro-, thermo-, balneo-, therapeutic apparatus, etc.) for the accommodation of local practitioners. Physicians may refer their cases to the Institute for such therapy as they deem necessary; associate members are privileged to invite and treat their own cases.

Thermotherapeutic department.

Otolaryngological department.

There can be no gainsaying the fact that the organization of diagnostic institutions possessing sufficient variety and quality of facilities to meet modern requirements does, as a rule, excite some opposition on the part of a limited number of local practitioners. But this opposition is based solely on a mistaken conception of the well-defined limitation of what is now meant by the term "diagnostic institution."

Opposition to the establishment of a diagnostic institution is based, in the main, on the contention that the modern hospital possesses all the necessary facilities for diagnostic investigations, and that, consequently, a disconnected institution devoted exclusively to this special branch of medical science is needless, if not an



Cardiologic department.

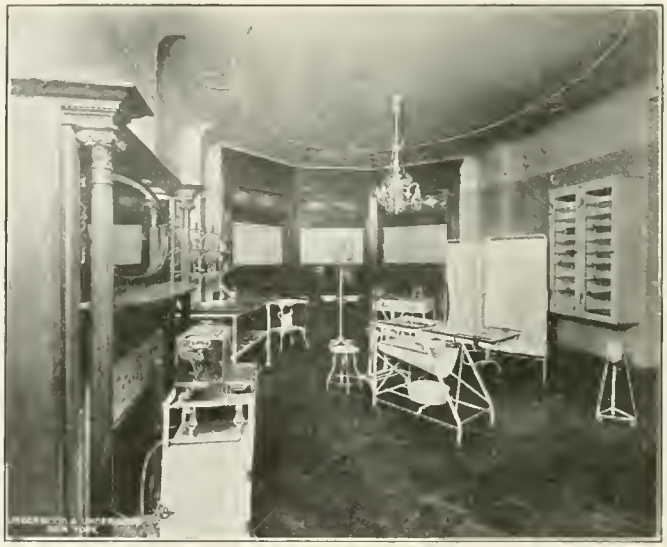
Electrotherapeutic department.

acual hindrance to hospital staff efficiency.

Time was when such a contention might well have been accepted as valid. But in this day of highly specialized training and better understanding of the importance of proper environment, it is entirely unjustified. In spite of their manifest interdependence, the clinician and the laboratory diagnostician work to the utmost individual advantage when in contact with their own kind, in separate environments. The clinician is at a disadvantage just so long as there remains in his mind the slightest uncertainty as to the nature of a given condition, and the laboratory diagnostician is at an equal disadvantage whenever he is permitted to share interest in the result of his treatment.

In the hospital, regardless of the scale of its departmental equipment, everything is subordinated to the restoration of a given case. Accordingly, the "atmosphere" of the hospital is that which acts as an incentive to the earliest and best possible discharge of the case. But in the diagnostic institution, everything is subordinated to the determination of the precise nature of a given condition, and the atmosphere is that in which a collaborative investigation to this end can be made under the most propitious circumstances. The skill of the clinician is brought to its peak by keeping him in contact with others, trained in their special field of activity. And the same holds true in the case of the laboratory diagnostician. The sum of experience is, that technical exactness and advancement are always greatest where contact of highly specialized minds is preserved.

Such flexible or imaginary boundaries of activity as are imposed on members of the staff of a hospital are a hindrance to individual efficiency and tend to lower the standard of institutional service. A biochemist should not be required to make a bacteriological investigation, nor should a morphologist be permitted to make a chemical analysis. And what is still more important, the accuracy of the investigations of a laboratory diagnostician should not be jeopardized by any interest on his part in what is beyond the prescribed limits of his own responsibility. When the clinician comes to understand that the collaborative study or group diagnosis of disease consists in assigning highly specialized minds to distinct branches of investigation, and the converging of their respective findings to a single conclusion, he will no longer consider it deserving of anything less than independent facilities; he will then realize why a diagnostic institution, in the modern acceptation of the term, bears nothing in common with



Cystoscopic department.

Gymnasium

the laboratories of the best equipped hospital.

Since experience has shown that it is an advantage to society and to medical science to assemble specialized talent and facilities for the treatment of, say, only neurological, ophthalmological, or gynecological cases, it must follow that it is equally advantageous to assemble other kinds of specialized talent and facilities for the single purpose of collaborative study, or group diagnosis, of disease. It is well to bear in mind the fact that a hospital is of benefit to only those who can enter its wards, whereas the service of a diagnostic institution is not limited to the bed-ridden, but is accessible to ambulant cases.

THE ORGANIZATION AND MANAGEMENT OF HOSPITALS

By H. C. WRINCH, M.D., Hazelton, B. C.

THERE are two principles that have been of late very much emphasized in all recent writing and discussion in the broad field of hospital development. One of these principles cannot be overworked, and cannot be too persistently drilled into the mind and thought and action of every hospital worker. It is included in the simple expression "highest efficiency." Concerning this principle, no further comment is necessary. It is accepted by everyone.

"Highest efficiency" and "hospital standardization" are much used terms at present in any discussion of the principles of hospital development. The first is accepted by everyone. The second also must be accepted, and in the development of hospital efficiency hospital standardization must play an important part. It is a means to an end, however, rather than an end in itself. With due regard to local conditions and differences of service, some constituted authority should check or regulate hospitals. Such regulation, even of private institutions, is justified for the public good. Yet the regulation must be such that the interest of the immediate community in the hospital will be stimulated.

The second important consideration finds expression in the term "hospital standardization." This also has come to stay, and is becoming the means of accomplishing much in bringing our hospitals up to the condition of highest efficiency.

It is the purpose and endeavor of this paper to add its bit to the development of hospital efficiency. To this end the principle of standardization will be advocated as far as it can be pressed into service, but with the clear understanding that it is a means rather than an end.

Local Conditions Must Be Considered

Having thus given pledge as to orthodoxy, the next principle laid down is that full recognition should be given to local conditions and requirements, especially wherein they differ from the ordinary. Even in arrangement of accommodation in building, local requirements should be considered. For instance, in an industrial plant where male workers predominate, with few women and children in the community, a hospital will be required with principal accommodation of public or semi-public character. On the other hand in a farming community, where the population is mixed in the normal degree a hospital will require more private and semi-private rooms for care of illness incidental to family life.

And of course the hospitals to be devoted exclusively to the care of special diseases should be designed and built so as to give the best conditions possible for the care of such patients. There may thus be three, or even more, hospitals of equal capacity, each requiring different internal arrangement to be best adapted to its particular purpose.

It is a remarkable, and surely an anomalous condition, in an age such as the present, when governmental control or regulation is brought to bear in so many ways in order that the rights and safety of the public should be safeguarded, that an important service such as that of hospitals should have been virtually ignored in many cases by "the powers that be." Certainly there is no service more vital to the well-being of our whole community than that in the hands of the hospitals. And yet, in so far as check or regulation by constituted authority is concerned they have been left to be originated, developed, and carried on, in very many instances, according to the ideas of individuals, private corporations, publicly or semi-publicly elected boards of trustees, in fact in any way whatever as local conditions appeared to demand, or permit, as the case might be.

And this refers only to the negative aspect of the situation, the regulation of such institutions as have been brought into existence by independent methods. It is too utopian to conceive of

a condition where constituted authority comes into a community and states that the population warrants, and its best health interests demand the establishment of a hospital within its limits? An established policy such as that would automatically prevent the independent action which has in the past, only too often, resulted in the establishment of small hospitals at points, or under conditions, which from the first precluded any possibility of success.

Small Hospitals Have Been Invaluable

Lest there should be any misunderstanding, I desire at this point to pay tribute to the invaluable services that have been rendered to our communities by the many hospitals by which they have been, and are still being, served. The credit to be accorded to the many persons instrumental in conducting our hospitals, should be all the greater because they have had to work so much of the time comparatively single-handed, negotiating innumerable difficulties, and breaking trails for themselves, and their way might have been made much smoother and many pitfalls avoided had there been an experienced hospital commission or committee "with power" to advise them and direct their efforts.

To my mind the first and by far the most important feature in the organization and management of our hospitals, big and little alike, is the bringing into existence of a wisely selected committee or commission on hospitals. That they should be persons of broad hospital knowledge and some experience goes without saying. They should be ultimately responsible to the local government, although not necessarily directly appointed by that body. In fact it would seem more reasonable that they should hold appointment under a council of hospital workers, organized along lines similar to the medical, legal, dental, and other councils.

Such a commission should have authority to inspect and examine closely into the methods and working of all hospitals, large and small, public and private, within its territory. It should, above all things, be sympathetic and constructive in its criticism. It would naturally decide upon certain standards. These standards would necessarily be graded according to the capacity or special object of each hospital, but should be such as would ensure to every patient admitted the best possible treatment. This might involve transference of certain patients to larger centers or larger institutions where more highly specialized equipment would be available. An institution that was found willfully ignoring the need of a patient for treatment such as it could not furnish, and holding him, either by misleading advice or by taking advantage of his ignorance, would be subject to censure or other pressure by the commission.

It may be claimed that such a course could not, or should not, be applied to private concerns. It would be an unwarranted intrusion upon private interests. The answer to this is that private interests must be secondary to the public good. No one can be allowed to trade in the greatest asset of the state, that is, the health of its citizens.

The only exception to the carrying out of this principle would be in the case of the patient himself, who might refuse to be transferred to another institution.

Having arrived at the conclusion, with the approval of the hospital commission, that a hospital should be opened at a certain point, the question of its organization in relation to the community becomes the most important matter.

Some would settle the whole question for all hospitals and for all time by vesting the entire responsibility, control, and administration in the government, but while this would appear to be the easiest way out and in many respects the most equitable, there are not a few persons who see in the system some very serious drawbacks.

Should Secure Personal Interest

A system that would best ensure the active personal interest of every member of the community to be served must be admitted the ideal one. The local administration should be vested in the people of each hospital community. A system of appointment of the board of management patterned somewhat after the school trustee system of British Columbia would serve the purpose. The honor of the position and the privilege of contributing to the welfare of the community should be sufficient inducement to enlist the services of the most broadminded persons in the district. An honorarium for partial or full time of one member of the board who would be responsible for secretarial or other necessary work, where it involved more time than could be reasonably afforded gratis, would satisfy the situation in cases where such conditions existed.

In comparison with the above system, the hospital organization under control of any philanthropic body, whether religious, fraternal, or otherwise, is handicapped in that it enjoys the active sympathy of only a portion of the people of any community. No matter how disinterested the motive behind the hospital project in these cases, there are but few that will escape criticism, or the imputation on the part of some, that there is some ulterior motive on the part of the organization concerned, for the furtherance of which the hospital has been thrust into the field. A very little of such adverse suggestion is sufficient to alienate

a considerable portion of the local interest which the hospital needs and to which it is fairly entitled.

Similarly the institution controlled and directed entirely by the government, with all appointments made by political methods, would meet with as much or even more indifference on the part of the general public.

It means a very great deal to the success of the hospital that it shall be so organized that every person in its district may think or speak of it as "our hospital." To my mind these conditions are best met when the hospital is under the direction of a local board of management, which is appointed in some manner by the people served by the institution.

It can be readily seen that the matter of financial support also, an all-important feature, although its discussion does not come within the scope of this paper, becomes an easier undertaking under this suggested organization than under almost any other method.

This organization should be found applicable, in a modified form to hospitals of any capacity.

Must Consider Size of Hospital

As to the management of hospitals there is probably more diversity of opinion than over almost any phase of hospital work. In this particular respect, the capacity or size of the hospital must be taken into account.

It is being more and more recognized that the position of a hospital superintendent is one requiring a more widely diversified range of ability, or even talent, than almost any other conceivable work. The superintendent of a large hospital holds a very important relation to the disbursement of very many thousands of dollars annually, hence he should be something of a financier, and be as able in seeing that the best value possible is obtained for the hospital's money as he is in devising or carrying out measures for obtaining it. He is in personal relation with a very large staff of employees, in widely diversified forms of work. In addition to this, which is a part of the task of the manager of every large business concern, the hospital superintendent is handling, as his raw material, a mass of humanity in the most difficult and often unreasonable form in which it can be found. Further he should be familiar with quality, value, and market fluctuations of a very wide range of commodities, in itself no small task. And by no means last or least, he should have a working knowledge of a group of complicated and highly specialized sciences, by means of which his associated staff are working upon this raw material, in the endeavor to turn out a finished product of health and happiness in the guise of a grateful clientele composed of convalescent patients.

Can anyone conceive of a stronger plea for a thorough training by years of experience for so responsible a position?

But to return to the detail of our subject. The superintendent of the larger group of hospitals should certainly be medically trained, and a man of experience, drawn from similar successful service in smaller institutions.

The superintendent of the twenty-five to one hundred bed hospitals should also be medically trained. Prior to receiving appointment in charge of such a hospital he should have experience of hospital administration acquired by a certain period of service on the staff of some other hospital, perhaps as an intern, and preferably also as an assistant superintendent, or head of some allied department where his capacity as an administrator may be tried out and developed.

There is a feeling that a special course of training should be instituted for hospital superintendents. Perhaps such a course would be valuable, and without doubt it would be if supplemented by the training through experience described above. But it is certainly open to question whether the special course of training without experience of successful work in a smaller sphere would justify engagement for the larger positions.

A question may arise as to whether there is sufficient work in the hospital of twenty-five to fifty beds to find profitable employment for a trained medical man, for if engaged by the hospital, and with outside doctors on the staff, he must not engage in private practice. The answer is that in the smaller hospitals of this group, the medical superintendent who is presumably a young man, can take over some of the duties performed by interns in the larger hospitals, or carry out some of the treatments usually given over to special operators. Among such duties would be administration of anesthetics, laboratory work, x-ray and other electrical treatments, supervision of case records, etc. Many of the practitioners in attendance at the hospital would be more than glad to be able to have such work done for them in the small hospital, as it is in the larger ones, and would welcome a medical superintendent who would work in harmony with them along such lines.

Trained Nurses in Small Hospitals

The third group, that of hospitals of less than twenty-five beds, would be hardly large enough to warrant asking a trained medical man to devote his full time to their superintendence. Such hospitals are now being very satisfactorily superintended by experienced trained nurses. It is not likely that this system can be very greatly im-

proved upon. For these positions, however, it is equally important that candidates for them be prepared by training and experience as assistants in larger hospitals.

In these smallest hospitals the woman superintendent would naturally combine with her other duties the direction of the nursing as well as of the kitchen department. In this way her time could be profitably occupied in a manner that would not be feasible for a medical superintendent, unless the position was held by a woman. This latter alternative might after all be the solution of the problem as to how every hospital should be under the direction of a medically qualified superintendent, which the writer believes is the ideal condition.

The discussion of management in the further detail of the various departments, with their chiefs and assistants, becomes a matter of adjustment according to requirements based on capacity of accommodation. The matter of instituting a sufficient number of departments, and having them adequately manned so that no one individual is either overworked or idle, is after all only a part of the duty of the medical superintendent. It is to him the trustees must look for the smooth-running of the hospital machinery, or at least the human element which enters into it. The board of management that finds itself continually harassed by friction among the employees or by constantly recurring difficulty in keeping the responsible positions on the staff satisfactorily filled, may look for the cause in one of three conditions, either (1) they are not providing sufficient means to secure the best individuals for the various positions, or (2) they are perhaps hampering the superintendent by not giving him a free hand in engaging and dealing with the employees, or (3) the superintendent lacks something of the required amount of tact, personal magnetism, or ability to get the best effort out of his employees. If the board is conscientiously satisfied that the fault does not lie in either the first or second condition, then it should very seriously consider a change of superintendents.

Staff Meets With Trustees

A method adopted and found productive of exceedingly beneficial results, was that of having a monthly union meeting of the medical staff with the trustees. This proved a great success in creating a sympathetic atmosphere. The plan is that as many as possible from every department come together at stated intervals, and spend an hour or perhaps two in considering means of avoiding interdepartmental friction, and promoting cooperation, with a view to improving the combined service of the institution.

The service to be reasonably expected at any hospital depends less upon the bed capacity of the institution than upon the number of specialists, in addition to the general practitioners, who are practicing at points convenient enough to permit them to attend the hospital. The hospitals in the larger group can, and are of course expected to furnish treatment, both medical and surgical, in every form approved by the latest developments in medicine and surgery. They are able to do this because they are located at the larger centers of population, where specialists in all departments are in active practice. Such specialized forms of treatment are equally available to the smaller hospitals situated within easy access of such a town or city.

The service in the two lesser groups of hospitals is necessarily more limited for the reason that such hospitals, or most of them, are located in smaller towns and rural centers. In such places it is obviously impossible to provide the more highly specialized treatments carried out by specialists. Thus hospitals are limited in range of service to such as can be furnished by the general and surgical practitioners on their visiting staff, supplemented by what can be carried on by the trained members of the hospital staff.

Small Staff Can Handle Special Treatments

It is quite feasible in hospitals of about fifty beds, with a visiting staff of five or more practitioners who are working harmoniously, to carry out a fairly wide range of special treatments. It could be arranged if the visiting staff would agree among themselves each to take up a certain specialty, and then fit themselves for that specialty by a moderate period of training of a postgraduate character.

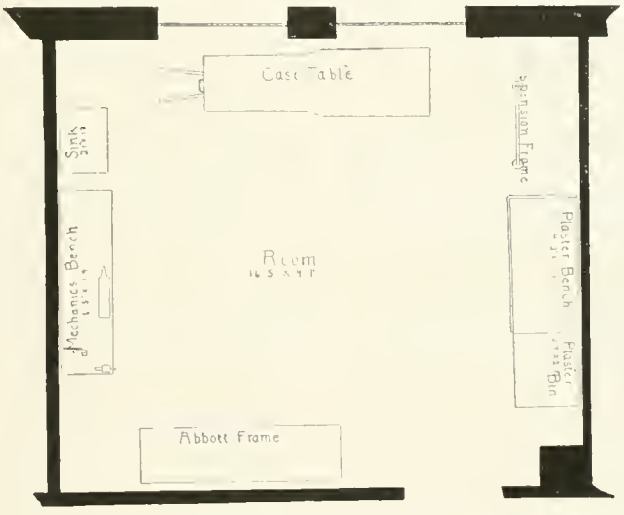
The medical superintendent of such a hospital, if a man of tact, could show the medical staff the great mutual advantages that would accrue both to themselves and the hospital by such a course. He would be a specially effective factor in the development of such a scheme if he would himself become responsible for such of the technical work, before referred to, that the visiting staff would be glad to have done for them. A point to be carefully guarded is that the income of the superintendent should be derived entirely from the funds of the hospital, and not from fees for carrying out any of these treatments. Any fees for such treatments should go directly to the hospital funds.

A policy on some such lines should be the means of creating and maintaining such cordial relations between the hospital superintendent and the attending staff as would enable them together to render the best possible service to the community.

THE PLASTER ROOM

By WILTON H. ROBINSON, M.D., Orthopedic Surgeon, South Side Hospital, Pittsburgh, Pa.

THE progress of orthopedic surgery in the last decade has included the development of some very excellent pieces of temporary apparatus. A few examples are the Lovett Removable Jacket and the Abbott Jacket, both for scoliosis; the Plaster Splint (Buchanan), the Jones Abduction Splint for the upper arm; the Thomas Splint with its endless possibilties for modification; various splints of sheet metal or wire mesh; the Pylon, used so extensively in England during the late war to induce early walking in the amputated. In addition to these there is an almost infinite variety of devices of a mechanical nature for the treatment of various types of fracture of bones and for maintaining proper position of extremities in spinal or peripheral nerve paralyses. Apparatus of this kind cannot be properly made or applied without some sort of special facilities. Therefore, it is desirable that the orthopedic department set aside one room for plaster and mechanical work. The advantages of such a room are probably obvious to anyone—but it may be mentioned as an excuse for the appearance of this article that it is a very rare thing to find in the average hospital sufficient equipment and tools outside of the engine room for the construction of the simplest splint.



Plaster room, floor plan.

Of course, there are special hospitals having their brace shop in the basement and with a plaster room in the operating room suite but this is something beyond the average institution. As a general hospital proposition, the need has been met at the South Side Hospital of Pittsburgh by the installation of a specially equipped room under the orthopedic service but, of course, available to any other service.

The main consideration was to bring as much of the plaster of Paris work as possible to one place and, if possible, at given times. It was also planned to bring to this room such simple bench equipment and tools as to render possible the emergency construction of any splint or other simple apparatus that might be needed.

The equipment consists of a cast table, an Abbott Frame, an upright suspension frame, a combined plaster bench and bin, and a mechanic's bench, the latter provided with a heavy vise, anvil and bench shear. There is a sink in one corner connecting by its drain with a large trap in an area way; this trap will take care of any excess plaster of Paris which gets into the drain. The taps over the sink are placed about twenty inches above its rim so that water may be run into any basin or bucket without having to tilt it.

The plaster bench includes, on one end, a cupboard or bin twenty-eight by twenty-four by thirty-six inches, this being large enough to contain one barrel of plaster of Paris which may be put in at a door in the front; the top of this bin opens upward to give access to the plaster when needed. The top of the bench proper, that part to the left of the plaster bin, is surrounded by an inch and a half coping to prevent plaster of Paris falling on the floor; the space under this part of the bench is closed in, has one shelf and a double door at the front and furnishes space for supplies; the dimensions of the bench proper are fifty by twenty-five by thirty-five and one-half inches. Some of the advantages of this type of plaster bench are: plaster of Paris is protected from atmosphere and in case of a long continued spell of wet weather may be kept at its best by burning an electric bulb in the bin, the heat of which is usually sufficient to drive off any excess moisture; convenience of having plaster just where bandages are to be made; last, but not least, having just one definite spot to make all plaster of Paris bandages.

Hospital Has Specially Equipped Room

The equipment of tools for such a room will depend on the work to be done. In our case we use the room only for making and applying the more temporary apparatus of plaster of Paris, with or without metal parts, in making simple splints or occasional changes in braces after they come from the instrument maker or brace shop. For this purpose the following tools are sufficient:

Plaster room, showing plaster bench and upright suspension frame.

1 heavy hammer.
1 cold chisel.
1 6-in. crescent wrench.
6 drills and corresponding taps and wrench. Twist drills, number 9, 16, 23, 29, 34 and 43.
1 draw knife or old catlin (for trimming torso models).
1 sewing awl.
1 or 2 files.
1 10-in. pipe wrench.
2 or 3 shirt knives.
1 saw.
1 light ball-pean hammer.
1 lead block (about 5 lb.)
1 screw driver.
1 hand or breast drill.
3 punches to correspond to drills, number 16, 23 and 34.
1 pair bending irons.
1 leather punch.
1 U. S. standard metal gauge.
2 or 3 linoleum knives.
1 grommet set and grommets.

The above tools should be kept locked up, preferably in a tool chest of some sort. Many of the articles resemble things used by mechanics about the hospital and mistakes may happen.

As small a stock of supplies as possible should be kept on hand in the plaster room. It should not become a storeroom. An excessive amount of supplies only leads to unnecessary expense through waste or soiling. While the following list may appear limited, it is enough, under ordinary circumstances, to have about:

Plaster room, showing mechanic's bench.

1 barrel French's dental plaster.
1 yard white cornplaster felt ½-in. thick.
10 or 20 feet hoop iron in ½, ¾ and 1-inch widths.
Moleskin and plain adhesive plaster.
3 or 4 yards 10-oz. canvas.
5 or 6 yards cotton batting.
5 or 6 feet ¼-in. galvanized wire mesh.
6 bolts crinoline.
Stockinette tubing in 3, 6, 8 and 12-inch sizes.
10 or 20 feet iron rods, 3/16 and ⅜ inches diameter.
Gauze and muslin bandages.
Some sash cord and traction blocks.
1 roll lintine.
Assorted sizes of splint wood.

In addition to the above articles there are, of course, plaster basins, large spoons, large refuse can, chair, leg rest, etc. The hospital stores should contain an adequate amount of replacement supplies, special splints and material likely to be needed.

MICHIGAN NURSES, ATTENTION!

In order that all non-registered, graduate nurses of Michigan may have the opportunity to register prior to December 1, 1921, another state board examination will be held in Lansing, Mich., December 6 and 7. All applications for this examination filed in the office of the board prior to December 1, 1921, will be considered under the term of the old law. All applications received after December 1, 1921, must qualify to ninth grade preliminary education and pay a fee of $15.00.

Applications will also be considered for the December examination from candidates who have been graduated from schools not yet approved by the board of registration of nurses.

Under the provisions of the new law, all nurses who have obtained Michigan registration, whether by reciprocity or by examination, should apply for a new certificate, which may be obtained without examination and by paying a fee of $1.00. Notification to this effect has been mailed to all nurses who have obtained Michigan registration either under the waiver, or by examination, or by reciprocity, during the period from 1909 to December 1, 1921; but, due to change of residence and probably other reasons, over 50 per cent of the letters have been returned to the office of the board.

All nurses practicing in Michigan and registered in other States, Canada, Great Britain, Ireland and other foreign countries are requested to write to the office of the board for a copy of the law, and are urged to file applications for Michigan registration before December 1, 1921.

CELEBRATE RILEY'S BIRTHDAY ON HOSPITAL SITE

The fact of unfavorable weather did not dampen the ardor of the hundreds of school children and many other persons who assembled on October 7, to take part in the celebrations of the anniversary of the birth of James Whitcomb Riley at the Riley homestead. This is to be the site of the Riley Hospital. The program which was under the auspices of the James Whitcomb Riley Memorial Association was made up of Riley poems and songs recited and sung by the school children and addresses by several speakers, including Dr. Charles P. Emerson, dean of the Indiana school of medicine, and Governor McCray.

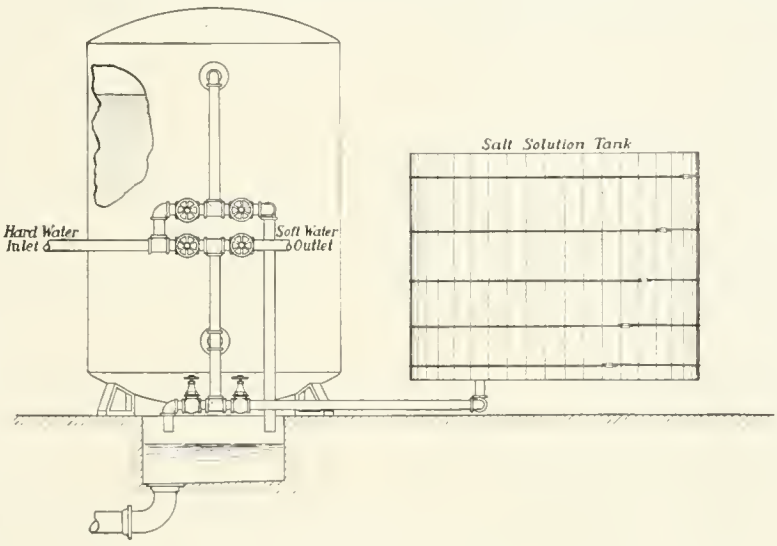
The governor pointed out that Riley's love of children as shown by his many poems written for them, made the establishment of a hospital for children an especially fitting memorial. At the close of the program which was held indoors because of rain, the governor planted a tree on the site of the proposed hospital.

SCIENCE IN THE HOSPITAL LAUNDRY

By WALTER TRIMBLE, Chicago

AS NEARLY every manager of a hospital laundry is in a fine position to have himself checked up by a scientist at frequent intervals, I wonder why so few take advantage of the opportunity. Nearly every hospital has a chemical and bacteriological laboratory in which many necessary tests could be made. As far as the chemical tests are concerned, any intern or drug clerk can make them with the apparatus which he will have at hand.

"Should one wash flat work and clothes in a washing machine that is used in washing pus-gauze or other infected material?" The foregoing question is one that was asked not long ago in the convention of an association of hospital managers, and, to my great astonishment, it was passed by without an answer being given, although several members indicated that they were anxious to get information on the subject, as it seemed to them to be an important one. I was astonished that the problem should be carried to the convention for solution by some of these superintendents, because I knew that they were connected with large hospitals that had bacteriological laboratories, with scientists in them who could quickly, by means of actual tests, give a correct answer to the query.



Standard zeolite water softening apparatus, as ordinarily installed in hospitals.

Any hospital manager who wants a correct answer to this question should send to the bacteriologist a supply of the gauze that has been washed, taking it direct from the extractor, and have it tested. If it proves that the gauze came out of the washing machine in a sterile condition, it seems safe to assume that the inside of the washing machine also was sterile. That is, one would naturally assume that a process that would sterilize the goods would also sterilize the machine.

But it is never safe to assume anything in a hospital process, so go a little further in the matter, in order to be sure. Scrape from the inside of the outer shell of the washing machine some of the soapy deposit which is likely to be found there in greater or less quantity. Take this material to the bacteriologist also, and have him see whether it is sterile.

In all likelihood, the deposit will be as sterile as the goods washed, for both have been subjected to the same degree of heat. Nevertheless, this slimy deposit should not be on the inside of a washing machine, and steps should be taken to remove it in case it is there. This can be done by the use of a hot acetic acid bath or two, followed by a hot rinse. Where soft water is used, this scum, which is insoluble lime soap, does not form.

If the head washman is required to take a few samples each day of the water used in his last rinses, and if these are tested in the chemical laboratory, it will be pretty sure to reduce the hospital's expense for fabrics. The tests are so simple that even a drug clerk can make them, and and no special apparatus is necessary.

For instance, where no "sour" is used there may be left in the goods enough alkali to do considerable harm, because of insufficient rinsing. Where a "sour" is used to neutralize the alkali, a test of the rinse water may show that the acid is not being rinsed out thoroughly, and this may mean that holes will appear in the goods.

In case the "sour" consists of a solution of oxalic acid, if it is not rinsed out thoroughly, it will concentrate as the fabrics dry, and this concentrated oxalic acid will eat small holes in the goods. If some of your sheets or other articles come out looking as though they had been perforated with shot this is the probable cause. In one way oxalic acid is an ideal "sour," for it removes iron rust and has what washmen call "a tendency to brighten up the goods." But as it will not evaporate with the water, it must be rinsed out thoroughly. On the other hand, acetic acid will not remove iron rust, but it will evaporate

*This is the twelfth of a series of articles by Mr. Trimble on the hospital laundry, which is appearing in THE MODERN HOSPITAL.

with the water, and therefore there is no danger that it will concentrate and eat holes in the goods.

There should be tests of the rinse water that follows the bleach bath, to see that all the bleach is removed, and there even should be occasional tests of the blueing baths, for these may show either too much alkalinity or too much acidity. If your head washman is the right kind of a man, he will cooperate with you and profit by these tests.

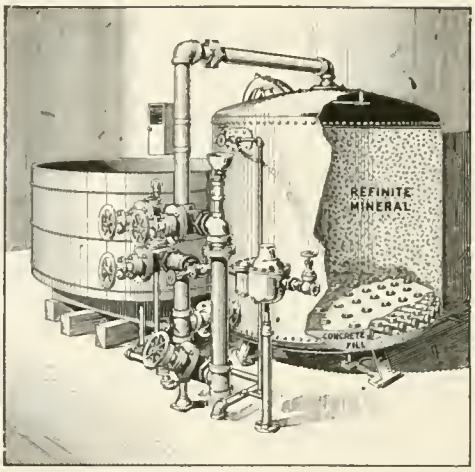
A few tests a day are not much trouble, they cost practically nothing and have a tendency to cause the washroom employees to pay strict attention to business and follow their formulas, especially if they do not know when some person will drop in and take samples of the water used in final rinses. I know of one instance where the adoption of this plan reduced an institution's expense for fabrics a substantial sum, and at the same time it reduced its bill for laundry supplies and secured a better grade of work.

As I have said before, if the hospital laundry manager will get acquainted with the chemist in his institution and get him interested, much good will come from this cooperation. There are many other ways than those I have mentioned in which the chemist, or even the pharmacist, can help the manager of a hospital laundry, such as the testing of bleach, soap, soda, acids and so forth, but I think that I have told enough to make it clear that the scientist should be consulted and his technical knowledge used.

Water Softening

In the July number of THE MODERN HOSPITAL, when I told of the advantages of using soft water I used the word "zeolite" several times, taking it for granted that all would understand its meaning. But as some readers seem to be confused in the matter, I will explain what it means in connection with water softening.

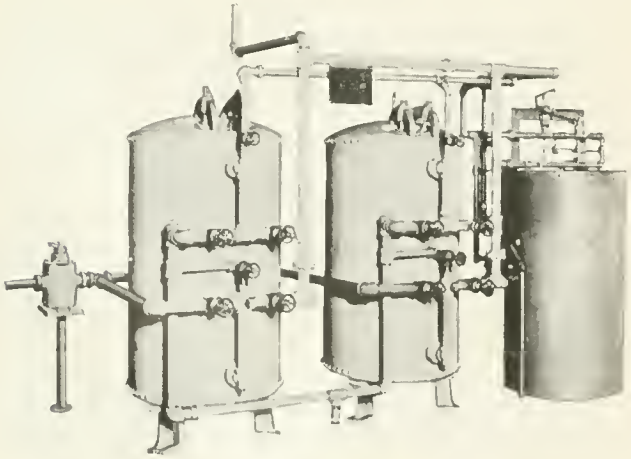
In the latest systems of water softening the water is filtered, usually under city pressure, through a bed of small particles of a mineral compound, the chemical name of which is zeolite. This mineral is not always referred to as zeolite, however, as each concern that makes a zeolite water softener has its own trade name for its softening substance. Three of the zeolite softeners are made by companies which incorporate the name of their softening agent in the name of their business. The zeolite may either be compounded or taken from a natural deposit. In composition it is analogous to the feldspars, their chief metals being aluminum, sodium, potassium, and calcium.



Industrial Model of Water Softener.

A quantity of particles of zeolite are placed in the filtering chamber of the water softener, and as the hard water flows through in a continuous stream it has all of its "hardness" (calcium, magnesium, and so forth) removed. As I have stated, each maker calls this zeolite by his own trade name. Harmless salts of sodium or magnesium, or both, are formed as the hard water passes through the zeolite, an instantaneous exchange taking place. This is a chemical exchange, not a reaction.

When the zeolite has neared its "exchange limit," or the point at which the water ceases to come out at "zero hardness," it is regenerated or brought back to its original state by a very simple process, which is the passing through it of a solution of common salt. When the salt solution is run through the zeolite, the reverse of the softening process takes place. That is, sodium replaces the destructive minerals, they are discharged into the sewer, and the zeolite bed is again ready for work. Practically no zeolite is lost through this action, so the only expense involved is the small amount that must be expended for salt. It is only necessary to regenerate the zeolite once each working day if a softener of proper capacity is installed.



A two-unit Water Softener and automatic brine tank, arranged for twenty-four-hour irregular but continuous demand for soft water.

A SANATORIUM FOR THE WELL-TO-DO

By EDWARD F. STEVENS, of Stevens and Lee, Architects, Boston and Toronto

PUBLIC sanatoriums designed for the treatment of tuberculosis of the masses are scattered throughout the country, and are supported by the state, the county, or the city; but private sanatoriums to furnish the same care for the well-to-do are less numerous and, like many private hospitals, some are being conducted in adapted private residences, giving splendid care but not planned to take advantage of all sunlight and air and freedom from noisy features.

One solution of such a problem is presented by the plans shown of the original development of the Central New England Sanatorium, an institution designed for the care of the better class of patients, where the home life is manifest—where each patient will have not only his own private room but his private balcony, as well; and where the lounge and the dining room are not only large, but palatial, with fireplaces and gallery.

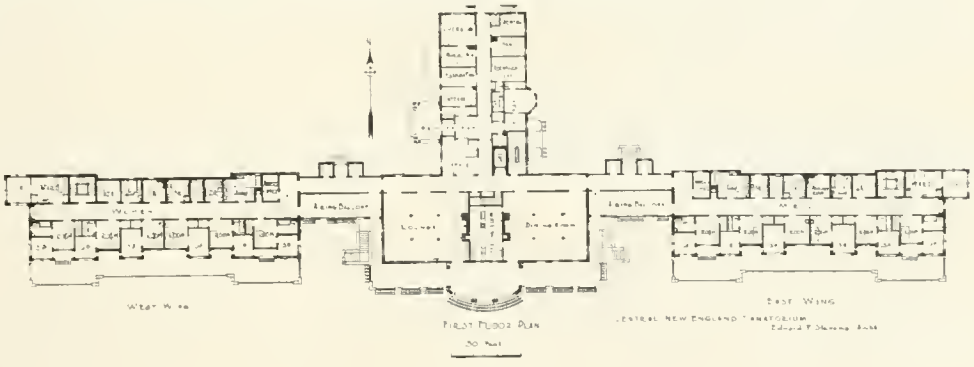
The site selected for this sanatorium is on the southern slope of one of the many hills of Massachusetts, in its highest and most central town, Rutland, and is approached by winding well-graded roads. The land is sub-divided to afford cottage sites and future extensions.

The administrative offices are placed in the north pavilion of the center portion, leaving an unbroken south front for sunlight and air. The lounge and dining room, extending through two stories, occupy the front of the center of the building, while the east and west wings are divided into patients' rooms and balconies on the south, and utilities on the north. On the first and second stories a private sleeping porch connects with each patient's room, and there are private baths for a majority of the rooms. A private dining room, serving kitchen, nurses' office, and other utilities are provided on each story.

Front elevation.

Ground floor plan.

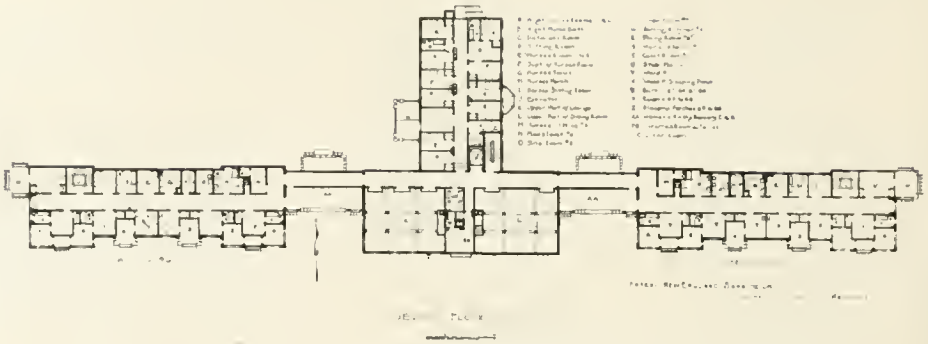
The contour of the land is such as to allow for an additional story at the front of the east and west wings. On this



First floor plan.

floor there are thirteen private rooms, with a common sleeping porch. The grade also permits of a light and sunny kitchen in the front of the central pavilion.

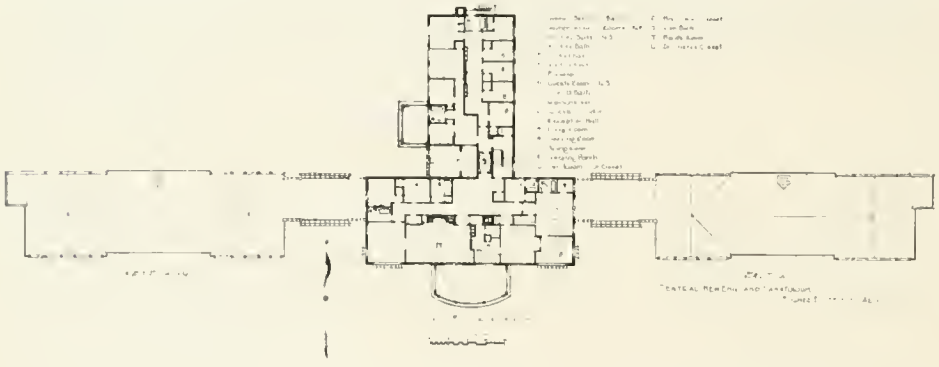
Covered and uncovered porches extend the entire south front. Even the servants' quarters have ample sun porches.



Second Floor Plan

The second story of the north pavilion will serve as a nurses' home. On the third floor are guest rooms for freinds of the patients, a portion of this story being used for servants' rooms, while the front of the central portion is planned for the use of the superintendent and his family.

If completed and carried out as planned, this sanatorium, with its cottages, camp, and workshop, will make a most ideal center for the care of tuberculosis.



Third Floor Plan

The institution is of tile construction, with cement stucco plaster finish.

SUPERINTENDENT VISITS HIGH SCHOOLS TO EXPLAIN NURSING

The following plan for recruiting pupil nurses has been used with great success by Miss Marie Louis, superintendent of the Muhlenberg Hospital, Plainfield, N. J.:

Just before the closing of the high schools of New Jersey, Miss Louis visits the high schools in a number of the nearby towns in company with from two to six of her senior nurses. She gets the permission of the principal to give a talk to the graduating class at the chapel exercises, at which time the several student nurses accompanying her also speak to the senior class explaining the high calling of the nursing profession and the advantages for training offered at the Muhlenberg Hospital. Miss Louis also obtains from the principals of the several schools lists of the graduating classes with their home addresses, and personal visits are made, followed up by a series of several letters to the girls at their homes during the summer. The result is that she always has her full quota of probationers and has an exceptionally good type of applicants from which to select.

JOHNS HOPKINS LOSES DR. K. H. VAN NORMAN

Dr. Karl H. Van Norman, first assistant director on the administrative staff of the Johns Hopkins Hospital has resigned his position to accept the directorship of the new Miller Hospital of St. Paul, Minn. It is a splendid opportunity, and a great compliment to Dr. Van Norman in having been selected for this post.

The Miller Hospital was completed and occupied about a year ago. It cost over a million dollars; it has a capacity of 225 beds, and a large children's department is still to be added, also a large outpatient department for the treatment of the ambulatory sick. This hospital will probably be used in connection with the University of Minnesota for postgraduate teaching. Dr. Van Norman is to take up his new duties as soon as Dr. Smith can make arrangements to relieve him at the Johns Hopkins Hospital.

Dr. Smith states that Dr. Van Norman has received several offers from other cities, and that he has realized for some time that it would be impossible to retain his services here indefinitely, but that Dr. Van Norman's going will nevertheless represent a distinct loss to him and to the hospital. Dr. Van Norman came to the Johns Hopkins Hospital in January, 1913, as an assistant superintendent. After the death of Dr. Rupert Norton he was made first assistant, which position he held until November, 1915, at which time he resigned to enter the service of the Canadian Army Medical Corps. He served in the Canadian Army for four and a half years, receiving various important assignments along the lines of administrative work in connection with the Canadian war hospitals. When Dr. Ralph B. Seem left in May, 1920, to accept the directorship of the Albert Billings Memorial Hospital for the University of Chicago, Dr. Van Norman returned and again took up his duties as assistant director at the Johns Hopkins Hospital, which position he has held since that time. Dr. Smith is unable to state at this time who his successor will be.

DR. SMITH HAS NEW ASSISTANT

Dr. Herman Smith, superintendent of the Michael Reese Hospital, Chicago, has a new assistant, Mr. L. C. Austin, who took up his duties on October 1.

THE NURSES' DORMITORY BUILDING AT KINGSTON, NEW YORK

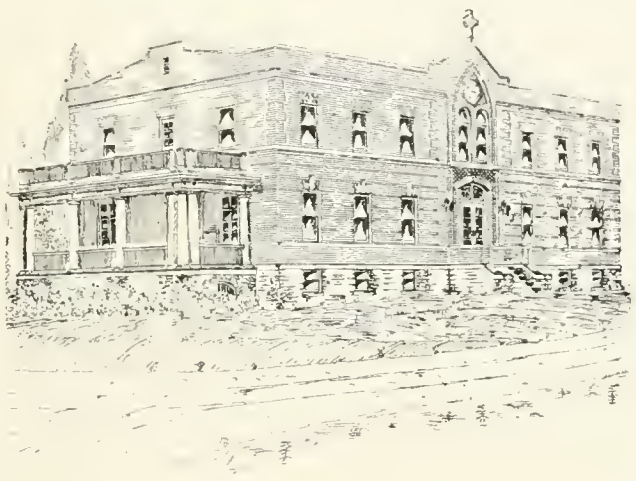
By GEORGE E. LOWE, Architect, Kingston, N. Y.

THE nurses' dormitory building for our Lady of Victory Sanatorium is situated upon a plot of ground having a continual rise in grade, from the street adjacent to the lower end of the building, until it meets the level grade, a distance of approximately ninety feet. In placing the dormitory upon the site, the governing factors were the nearness to the hospital building, the outlook, and the grade above described. The plot is very hilly and rocky, and is situated on the outskirts of the city, away from noise.

The building is so placed on the site that an extension to the present hospital is made possible without any interference with the nurses' dormitory, and after this addition is built, the dormitory will be within thirty-five feet of the hospital proper.

The site commands a view of the city and the picturesque Catskill mountains in the distance.

One enters through a vestibule, the main hall, which contains the main stairway. The floor and base of the hall is of composition, as also are the treads and platforms of the stairs; the stairs are built entirely of iron and composition with a small wood hand railing.



Nurses' dormitory building, Our Lady of Victory Sanatorium, Kingston, N. Y.

The side walls and ceilings of the hall are of plaster, finished at the base with a painted burlap wainscot, and at the angles of the side wall and ceiling with a wood cornice. The panel in the ceiling opposite corridors is formed with wood beams supported at ends upon wood pilasters, this treatment giving distinction to the doors which lead to the living and sleeping apartments, adjoining the main hall on this floor.

The floors and base are of tan color composition, the burlap wainscot is painted a slightly lighter color, while the walls above the wainscot are of buff. The cornices, pilasters, and other woodwork in the hall are natural Tennessee chestnut, finished brown color; the ceiling panels are of ivory white. All the doors leading from the hall to corridors are glazed and divided with wood muntins. Doors to sleeping apartments are translucent glass; others transparent.

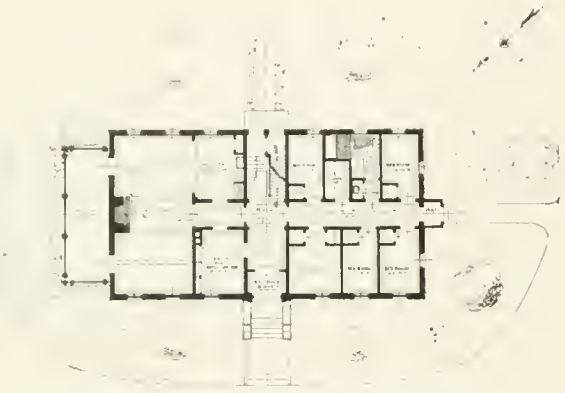
It can readily be realized that this main hall, its disposition of entrances, and its general color scheme, can only give a reception of welcome and a homelike atmosphere, which necessarily should exist in a home of this character.

A large living room, with beam ceiling, painted burlap wainscot, tapestry brick fireplace, with tile hearth, and having hardwood floor, is located at one end of the building and entered from the main hall through a passage which separates the remainder of the living apartments from the living room. The remainder of the living apartment is composed of a library and reception room, containing bookcases, and a classroom which contains a white enameled sink, electric range, cupboards necessary for dishes, etc., a refrigerator with connected waste to sewer, a closet for supplies and paraphernalia used during class work. The floor of the classroom is of composition. A folding partition separates the classroom from the living room, this feature being incorporated in the plan so that the end of the living room can be utilized together with the classroom, for class work, thus eliminating the necessity of a large classroom. Of course, the reason for a large living room is the fact that it can be used by house parties, otherwise a smaller living room would meet all the requirements. When a house party is being given, a buffet luncheon can be prepared and served from the classroom, which is equipped for such purposes. Adjoining the living room is a private porch running practically the full length of the building which is ten feet in width, it being reached through French casement windows from the living room. The sleeping apartments on the first floor are separated from the living apartments by the main hall.

A bathroom with ceramic tile floor, base, and wainscot, with all bathroom accessories, porcelain

lavatory and closet with flushing valve, is provided on this floor, as is also a linen closet with sanitary composition flooring and a janitor's sanitary sink. The center ceiling light in the closet is operated by a jamb switch when the door is open, and automatically turned off when the door is closed.

There are eight bedrooms in the building, accommodating one nurse each, and four accommodating two nurses each, taking care of a total of sixteen pupil nurses. Each of these bedrooms



Plan of the first floor, nurses' dormitory building.

contains separate closets for each nurse, complete with shelving and rod for coat hangers. The trunks are kept in a trunk room in the basement, directly under the living room. The night nurses have been provided with separate rooms with connecting bath, having ceramic tile flooring base and wainscoting with built-in tub, accessories, and beveled plate mirror the full height of the door.

On the second floor the bath room is separated from the toilet room. The bath contains built-in tubs, porcelain lavatories, and all bathroom accessories, and the tubs are placed in separate compartments whose partitions are elevated above the floors and separated from the main room by a tile curbing. The closet door between the two baths has a mirror of full height, and the closet is used for access to the plumbing for the tubs, and also for a storeroom for bath supplies.

Overhead showers are provided over each of the bath tubs, with mixing valves which control the temperature of the water.

The toilet room has a composition floor and a wainscoting on the side walls of "Keenes" cement marked off in imitation tile.

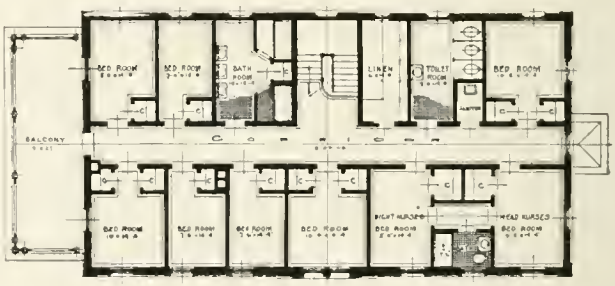
The second floor is also provided with a linen closet, and a janitor's sanitary closet is provided for on the first floor. At the end of the second story corridor, over the porch of the first story, will be found a balcony for the use of the nurses on the second floor. The floors of the corridors are of composition flooring, with base, and a painted burlap wainscoting is placed on side walls. At the right of the building is the first story corridor, in an entry which gives access from the hospital building to the nurses' dormitory, and as mentioned before, is about thirty-five feet distant from the new addition which will be shortly erected.

The exterior walls of the building are faced with selected hard burned North River brick, laid in pattern, and in red colored mortar, with tooled joints. The trim is of cast artificial stone. The general exterior treatment harmonizes with the present hospital building.

All corridor and stair enclosure walls are of masonry construction, as well as all exterior walls, with direct plastering, no furring. Exterior walls are backed up with hollow tile. All other interior partitions are of frame, and the floor and roof construction is of frame. The roofing is of fireproof material and all roof water is drained through interior drains.

The building is equipped with a modern heating system with graduated valves on the radiators controlling the heat in the several rooms. An advantage with this system in the dormitory building is that the windows may be left up in cold weather without any possibility of freezing and cracking the casting.

All interior trim is of Tennessee chestnut, and there is no trim placed on any of the window openings of exterior walls, or on the corridor side of doors, as plaster reveals are placed at these window and door openings. Each room has a central electric light fixture controlled by switch,



Plan of the second floor, nurses' dormitory building.

and a base receptacle outlet for table reading lamp, which also may be used for electric vacuum cleaner.

The ceiling fixtures of the bedrooms are of the indirect type and in the living room are of the standing candle, pan type, suspended by center chain; all of Flemish brass finish.

The hot water for the several fixtures in the building is supplied from a hot water storage

tank and heater in the boiler room and basement. The plumbing system is of the best, well ventilated, and having all modern fittings. The reason for the flat roof construction of this building is that if there were an attic over the second story, it would be a catch-all and a fire trap, and if it were converted in time into sleeping apartments, it would necessitate the erection of fire escapes, as required by the state law, and this would mar the appearance of the building.

Registers are placed in the ceiling of the second story corridor directly under the ventilators in the roof for ventilating the attic space, and also the corridors.

The building, inclusive of porches contains 75,000 cubic feet, and the cost is approximately fifty cents per cubic foot, making a total of $38,000. The building is thirty-five by sixty-five feet with ceiling heights of nine feet.

HEALTH FORTNIGHT MARKS PUBLIC HEALTH MEETING

The fiftieth annual meeting of the American Public Health Association will be the occasion of a Health Fortnight. From November 8-19, New York City will be the scene of activities connected with this event, and the publicity, with its slogan "Health First," will stimulate interest throughout the country.

Health Fortnight will include three major divisions—a Health Institute from November 8-11; a Health Exposition, November 14-19; the Fiftieth Annual Meeting of the American Public Health Association, November 14-19. Representatives from virtually every state in the Union and from many foreign countries will participate in the extensive program.

To focus the attention of the general public upon this celebration, November 13 will be observed as Health Sunday in many churches. Health Day will also be observed in the synagogues and in numerous business and social organizations. Speakers prepared to talk authoritatively on health topics will be furnished on request to any of these organizations. The New York County Chapter of the American Red Cross is cooperating with the general committee in the arrangement for this service.

The Public Health Exposition will undoubtedly make the widest appeal to the lay public. It will be the largest affair of its kind ever held in New York City. It will be conducted under the joint auspices of the Department of Health of the City of New York and the American Public Health Association. Already allotments of space indicate that at least two entire floors of the Grand Central Palace will be occupied by exhibitors. The exhibits will include those of educational and philanthropic organizations and those of commercial houses producing approved articles of health value.

Every legitimate means will be utilized to promote attendance at the exposition, for this will be the most effective way in which the message of Health Fortnight may be brought to the public. The fact that a similar health exposition held in Chicago a year ago drew an attendance of over one hundred thousand indicates the extent to which this form of popular education may be carried. Naturally, in New York, with its larger population, a proportionately greater attendance is expected at the exposition. The profits from the sale of tickets, after the cost of the exposition and the convention is defrayed, will be devoted to establishing nutritional clinics for the benefit of undernourished children. In this connection, Dr. Royal S. Copeland, health commissioner of the City of New York, will present a series of educational exhibits in which instruction in the feeding of children will be featured. Dr. Copeland is chairman of the exposition; A. W. Hedrich of the American Public Health Association is secretary, and Dr. C. E. North, treasurer and general manager.

The Health Institute from November 8-11, will present to visitors to the convention an unusual opportunity to see the operations of established methods applied to various phases of public health work. About forty demonstrations have been planned.

Following the week of the Institute and the observance of Health Sunday, will come the opening of the scientific sessions, the meetings of the American Public Health Association in celebration of its semi-centennial. The sessions will begin on November 14 and the headquarters will be at the Hotel Astor, Broadway and Forty-fourth Street.

The founder of the American Public Health Association, Dr. Stephen Smith, although in his ninety-ninth year, is still active and will participate in the meeting. A banquet will be held in Dr. Smith's honor as a part of the semi-centennial celebration.

As a permanent souvenir of the semi-centennial and as a record of the work accomplished, a Jubilee Historical Volume entitled, "Fifty Years of Public Health," will be ready for distribution during Health Fortnight. Although, as the title indicates, the book concentrates on progress made in the last half century, it also traces the public health movement from its early beginning. Further information regarding the semi-centennial may be obtained from the American Public Health Association, 370 Seventh Avenue, New York City.

PUBLIC HEALTH SERVICE TO HOLD TWENTY-FOUR INSTITUTES

In response to a preliminary announcement of the Public Health Institute, which the Public Health Service had planned to hold in Washington this fall (but which has been postponed indefinitely), a large number of city and county health officers, physicians, nurses and others replied indicating a definite intention or hope of attending.

The Public Health Service felt that it could not ignore this widespread interest in institute work, and after correspondence with the various state boards of health, decided to hold a series of twenty-four institutes at various population centers throughout the country.

It is expected that most of the well known specialists announced for the two weeks' institute in Washington will be on the faculties of two or more of the various local institutes. No tuition will be charged.

The centers will include such widely separated points as Chicago, San Francisco, Hot Springs, and Washington. The schedule of courses, which will probably be adopted with some alterations by the various institutes, includes the following subjects: syphilis, tuberculosis, nutrition in health and disease, the delinquent, the general communicable diseases, child hygiene, industrial hygiene, and sanitary engineering.

The board of trustees of the county hospital at Hartford, Ind., has been receiving bids for an $80,000 building, to be of brick, two stories and basement.

THE ADMITTING AND EMERGENCY UNIT OF THE NEW YORK HOSPITAL

By JOHN A COLUCCI, M.D., Admitting Physician of the New York Hospital, New York City

THE admitting and emergency unit of the modern hospital is now generally recognized as one of the most important departments, if not the most important, in the large general hospital. Here all cases are received no matter what the character; here, too, the diagnosis must be made and the first treatment administered. It is comparable to the sampling room of a factory, the registration desk of a hotel, or the information bureau in one of the railroad terminals. The centralization of authority and the concentration of emergency facilities are chief factors in the building up and equipment of an admitting and emergency unit. It is because this centralization and concentration have reached such a high state of perfection at the New York Hospital that this article is written and this system highly recommended.

Old Department Unsatisfactory

This department of the hospital under the old plan of organization proved to be entirely unsatisfactory. Nothing short of complete reorganization could remedy its many defects. The admitting and emergency departments were practically two distinct units. The functions of the former were chiefly administrative, financial, and clerical, while upon the emergency unit rested the responsibility of treating the accident cases. The ambulance surgeons and surgical juniors constituted the emergency unit and were subject to call according to the following arrangement:

Monday, Tuesday and Saturday

First call for dressing cases: First Ambulance Surgeon.

Second call for dressing cases: Third Ambulance Surgeon, to 6 p.m.

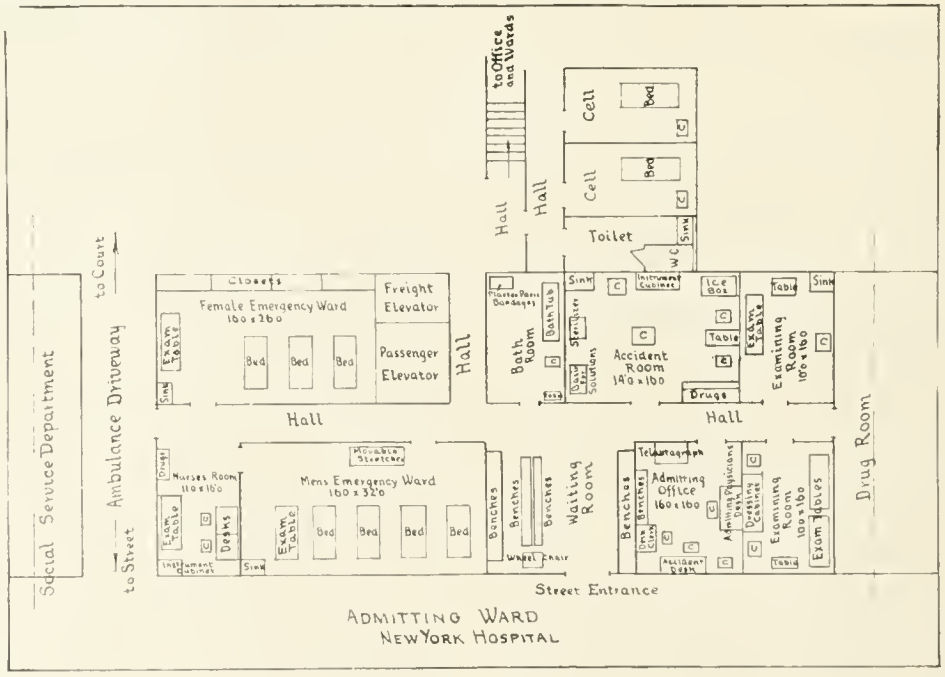
Third call for dressing cases: Until 6 p.m. Surgical Junior takes second call for dressing cases.

Wednesday, Thursday and Friday

First call for dressing cases: First Ambulance Surgeon.

Second call for dressing cases: Third Ambulance Surgeon, to 3 p.m.

Third call for dressing cases: Until 3 p.m. Surgical Junior. After 3 p.m. Surgical Junior takes second call for dressing cases. No third call after 3 p.m.



Floor plan of the admitting and emergency unit of the New York Hospital.

Sunday

First call for dressing cases: First Ambulance Surgeon.

Second call for dressing cases: Surgical Junior.

No third call for dressing cases.

All medical treatment cases were treated by the medical second senior on ambulance duty.

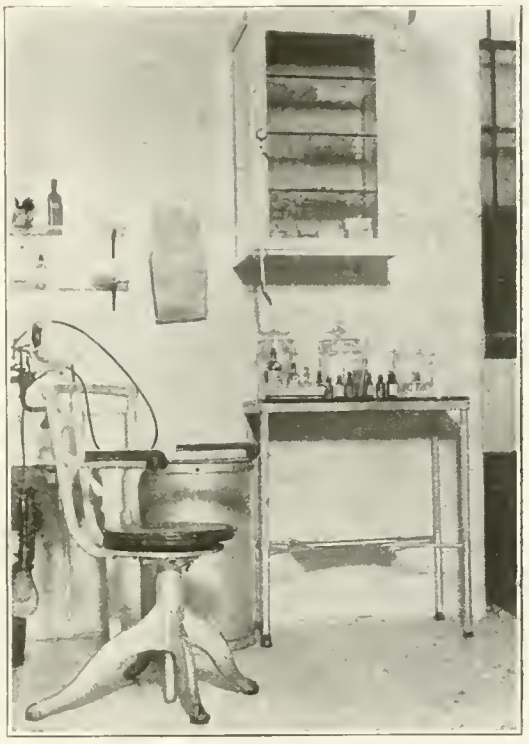
Old Procedure Necessitated Delays

Upon arrival of an accident case at the hospital the nurse in charge of the emergency ward notified the intern who was subject to call. Such a procedure not infrequently involved considerable delay in the treatment of such cases. Ward duties too often occupied the attention of the nurses and interns; delay in the conveyance of messages and difficulty in locating the interns, at times, were partly responsible for the inefficiency of this department. But, that which was most conducive to this inefficiency was the fact that the ambulance surgeon's time in the accident room was frequently interrupted by ambulance calls. For instance, during the year 1920 there were 5,853 ambulance calls, averaging sixteen per day and varying from a few to as many as thirty-seven calls in a day. Needless to say, the efficiency of this department, based on such a scheme, bore a definite relation to the type of intern. Much depended upon his personal qualities. While it is true that the present plan deprives the intern of the experience that can be derived from the accident department, it is true only in an official sense. He is not denied the privilege of treating accident cases under the guidance of an experienced admitting physician. On the other hand, the interns are encouraged to spend their spare moments in the accident room and are permitted to choose and treat what cases may prove of interest to them.

Present Plan Eliminates Delays

Avoidance of delay, therefore, in the treatment of emergency accident cases, constituted the main object in the development of the present plan of organization. Ordinarily, the extent of most injuries are, in the eyes of a physician, very trivial; but, to the patients, they are often a source of grave apprehension, and where delay in the treatment thereof is unduly prolonged, the good name of the hospital and its constituents suffer, frequently being subjected to severe criticism. That this defect in the emergency department might be remedied as completely as possible, it is evident that a physician must needs be in constant attendance in the accident room, so that the accident cases may be given immediate attention. It was therefore deemed advisable to have the admitting physicians treat the emergency accident cases, thereby combining the admitting and emergency departments into one unit.

Three salaried admitting physicians are employed, each on duty five and one-half hours a day, and in all, covering a continuous period from 7 a.m. to 11:30 p.m. Only young, energetic, and practicing physicians are accepted for such a task. Under the old plan, the admitting physician was burdened with all the clerical work necessary for the admission of cases to the hospital, together with innumerable other minor office duties, all of which could easily be entrusted to an efficient clerk. That his time, therefore, might be devoted entirely to the examination of patients applying for admission to the hospital and the treatment of all emergency and accident cases, a clerk was added to the personnel of this department. Experience has proved this to be a very happy and fruitful arrangement, and, with the assistance of a nurse and orderly, puts this department on a very practical basis.



The treatment room is fitted with all necessary facilities for treatment.

In order that the working efficiency of this newly organized department should approach the point of perfection, it was found necessary to rearrange the setting of the rooms comprising this department, the essential being economy in time and labor. The accompanying plan shows in detail the composition of this department of the hospital, and, as will be seen, the necessary advantage in concentrating its various activities over a small area. Originally, the social service department carried on its activities where the admitting office is indicated on the accompanying sketch, the admitting department in the waiting room and the accident department in the social service room. In our experience, such an

arrangement proved entirely unsatisfactory, the greatest disadvantage being in the unavoidable waste of time, in that the admitting physician was forced to treat the accident cases at the one end, and examine cases for admission at the other end of the floor. Besides its great advantage in the economy of time and labor, the present scheme allows all the activities of this department to be under the immediate control of the admitting physician. Here he has all the patients before him and can arrange his work according to the degree of emergency in each case. He is ever present to receive all cases that are referred to the hospital for admission or treatment, and does not have to depend upon being notified of the arrival of any patient by the nurse or orderly, as was necessary under the old plan.

Department Now On First Floor

This department is located on the ground floor and the entrance to it leads directly into the waiting room, which is in immediate connection with the admitting office, the accident and examining rooms. Ambulatory accident cases are escorted directly into the accident room, treated, and then referred to the admitting office to interview the clerk, who, after obtaining the patient's pedigree, gives him a dispensary card and the necessary instructions. The history of the case is entered in a yearly record book and also on a history blank, the latter being sent to the dispensary the following morning, where the future course of such accident cases is followed. Non-ambulatory cases, whether accident or ordinary medical and surgical, enter through the ambulance driveway and, with the assistance of the nurse or orderly, are prepared for examination either in the emergency wards or the examining rooms, depending upon circumstances. In all, there are six examining tables conveniently arranged to meet all purposes and not at all too numerous in times of emergency like the Triangle Shirt Waist Company fire and the recent Wall Street explosion. Cases suggesting the necessity of an immediate operation are referred at once to the house surgeon, who, in turn, after recording the physical findings and the necessary laboratory data, reports to his attending surgeon, upon whom rests the responsibility of deciding whether or not the cases need immediate operation. The disposition of all cases applying for admission is in the control of the admitting physician, subject, of course, to certain rules and regulations. In the case of children, as a means of precaution, nose and throat cultures, the Shick test, and, in the case of female children, a vaginal smear, are taken before they are admitted to the wards. Any patient, whether child or adult, with any suspicion of a contagious disease, is referred to the proper hospital. Here, in this connection, it is well to point out the importance of a bathroom in the admitting department. All patients, except the very sick and the women, are obliged to take a bath, and have their clothes and valuables listed with the orderly or nurse, before they are admitted to the wards. Cleanliness, of course, is the main object, but frequently it reveals many objectionable skin and venereal diseases.

There are six examination tables conveniently arranged and not too numerous in the emergencies which sometimes arise. At the right of the picture is one of these tables, and at the left is shown a nurse's desk.

Non-ambulant patients are prepared for examination either in the emergency wards or in an examination room, one of which is shown here.

Disposition of Cases Convenient

The detail arrangement of the admitting and emergency department is sufficiently indicated in the accompanying sketch, necessitating no special comment, except that they have been so arranged to permit of the most convenient and most rapid disposal of the cases. The accident room is so fitted as to afford every facility for the treatment of all minor surgical accident and emergency

cases, including fractures. With fracture cases, of special importance are the facilities of the x-ray department, situated on the next floor, where, with the aid of the fluoroscopic x-ray machine, exceptionally good results in their reduction can be obtained. It also helps in establishing a correct and immediate diagnosis.

A word about the amount of activity of this department of the hospital will not be amiss. During the year 1920, six hundred fractures were treated, while the ordinary dressing cases and minor operations numbered 6,750, averaging twenty cases a day. In the same year, 5,944 patients were admitted to the wards of the hospital. These figures, together with the other activities of this department, indicate roughly the amount of work accomplished by the department and the important position it holds in the hospital. Indeed, it is safe to say that it is unquestionably the most responsible department of the hospital as it covers a multitude of activities, administrative, financial, clerical, medical, and surgical, which are of vital importance to a busy modern hospital.

COUNTRY CONVALESCENT INSTITUTIONS FOR HEART DISEASE*

By FREDERIC BRUSH, M.D., Medical Director, the Burke Foundation, White Plains, N. Y.

THE recuperation of the heart diseased in country institutions has advanced so rapidly in the past five years that certain approximate standards are forming. These are of value, especially to communities that are just beginning organized health effort in this branch. Progress has come through: (a) the gradual overcoming of the prohibitions against cardiacs in existing homes; (b) the establishment of special heart-convalescent places; (c) broadening and elaboration of function in the various homes, and (d) better cooperation in the selection, preparation, convalescent placing and occupational follow-up.

More uniformity and surety exists in the requirements for cardiacs than for the other classes of convalescents—the needs of the latter being more ameliorated by the living, recreational and standard health care conditions of each community. But heart patients cannot be hurried from the hospitals or their homes to get along fairly with average dispensary and private after-care; they need prolonged bed-treatment, and to be graded through country convalescence into environment and occupation suitable to each individual—or the equivalent via clinic and home direction. They require, furthermore, occasional *re-convalescent periods and preventive recuperations.* Thus heart care plans for one American city will fit others measurably well.

It is mainly this clear and stable need that is now causing heart convalescence to outgrow other kinds, proportionately.

In the recent health program for the city of Cleveland more than one-fifth of all proposed convalescent beds were given to heart disease; and in actual operation now in New York City nearly one-sixth of such beds are for this condition. In an American city of one million population (a convenient planning unit) there are at least twenty thousand persons with heart disease. Experience so far points to a working estimate of from three to five per cent of these (six hundred to one thousand) in need of institutional convalescence in one year, bringing a requirement of from sixty to one hundred year-round beds (with average stay of five weeks). Adopting the one hundred bed requirement, the classification may be suggestively worked out by the allotment of thirty beds to adults and seventy to children from six to fifteen years old—arranged feasibly somewhat as follows:

1. Adults of both sexes to have entrance to thirty beds in one or more general convalescent homes where some special direction is afforded.
2. A separate institution receiving ten boys from six to ten years old, with twenty-five girls aged six to fifteen.
3. Fifteen older boys (ten to fifteen) to be

Cardiacs in a short-golf tournament on the slopes of the Heart-Cottage.

*Paper read before the College of Physicians of Philadelphia, May 4, 1921.

treated along with others in a general convalescent boys' home.

4. Twenty sicker children of both sexes and ages up to fifteen, and requiring considerable bed and reclining care at first, to have a specialized place.

This ratio would give New York City from five to six hundred beds for heart convalescence; and that this is not a fanciful or too ideal city plan is indicated by the rapid growth there to a present provision of over three hundred beds—with large extensions in prospect; five-sixths of these three hundred beds are for children, which is too high a proportion (note the two-thirds proposed above), for while childhood, and adolescence particularly, are the proven periods for best reconstructive and preventive results, it is recognized that more adult cardiacs, and especially men under forty-five, should have access to such homes.

Types of Homes and Functions

Heart convalescents in institutions require regulated rest, graduated exercise, mental readjustments generally, directed work and play-therapy, continuation schooling if young, some beginning vocational guidance, and end-linking with suitable occupation and years of follow-up. But all of these functions are coming to be demanded of our general convalescence, and are precisely adapted to it. It is a far step from the few older rest places and retreats to this new, essentially American convalescent health-plant with its active tonic and formative atmosphere; and every one of *these general homes* (children and adult) *should receive the properly selected and prepared heart convalescents;* and may be assured of safety and success with them. The mistaken idea that cardiacs will be endangered by too active association with other convalescents is giving way to the understanding that they tend rather to a faulty inertia and under exercise, and that they will grade almost automatically into the various upbuilding activities. The mental and habit effects

The patients laying a walk under supervision.

The heart patients find haying not too strenuous as an occupational exercise.

of this mixed grouping are most valuable, simulating everyday life—being prepared for it. We are probably in the stage of too much segregating of cardiacs. Certain special heart homes for children in the more seriously crippled classes are undoubtedly essential.

The importance of the country location with ample grounds can hardly be overestimated; it is the out-of-door rest, play, work, grade-walking, and the inspiring anti-neurotic general all-day activities that must make up the major portion of the restorative and heartening interests, compared with which indoor gymnastics can give but scant results.

Providing the Facilities

No one expects an ideal plan to be precisely realized in any community. Practically, first should come acceptance of the *idea that any scheme of cardiac care includes country convalescent outlets.* Next is the getting of heart patients accepted in the existing homes, and having them definitely planned for in those under development. Then will come means and sympathetic interest from many and often unexpected sources, to establish new places, for children especially; and each of these should be promptly accepted and fostered. Time and experience and the assured successes will mould them into varied appropriate functionings.

Certain facts kept to the fore aid in getting and extending these desired provisions: Institutional heart convalescence is as safe and manageable as other kinds, demands but little medical oversight, may be well done in mixed grouping or separately, requires no new or expensive buildings and equipment, and yields results of such high order and permanence as constantly to astonish its patrons. It is an essential in any community health scheme.

Costs are about one-half that of hospital care—

or from $1.50 to $2.00 per day per capita—requiring, e.g., from $15,000 to $20,000 per year to run thirty beds. There is little prospect of its overextension, for the broad *preventive phases* (including prevention of heart disease incidence and of diseased heart overstrain) *are mainly undeveloped*. Convalescent organizations and methods are now sufficiently standardized so that full information is readily available.

"Fresh-air" camping and various recreational outlets are contributing factors in the prevention and recuperation of heart disease. On the other side is the question of institutional provision for the more seriously crippled—the cardiac invalids; but this requires separate study, and is not here included in the convalescent problem, though bordering it closely and constantly interchanging with it.

RED CROSS CARRIES ON FAR-REACHING ACTIVITIES

Public health nursing and the establishment of health centers are the two chief activities by which the American Red Cross is developing its public health program. Health centers have met the great need for coordination of health agencies and the bringing of these agencies into closer contact with the local, state and national official agencies, and the great body of doctors of the country. Of the 503 centers in the United States reported to National Red Cross Headquarters up to September 1, 1921, Red Cross chapters support wholly or in part, 407. These centers have become health information centers, and in the first six months of the year 100,000 inquiries were carefully answered. They have been the means of a wide distribution of health literature prepared by experts in all phases of health. During the first six months of this year 270,000 pieces of health literature were distributed.

Red Cross chapters have met the need for clinics in hundreds of communities always in such a way that the field of the physician is not invaded, and that the community as a whole benefits. Mostly they are located in health centers, but sometimes they have been conducted as separate projects. During the first six months of the year nearly 5,000 clinics have been conducted.

The great need for health knowledge has been met in part by the organization of Health Lecture Courses, and during the first six months of the year nearly 15,000 have been provided by Red Cross chapters.

Many chapters are promoting health education by constructing and conducting health exhibits, the use of health moving pictures, the Health Clown, health playlets and health clubs. During these six months 700 health exhibits were held and more than 1,500 health club meetings conducted.

Plans for the future contemplate the extension of all these activities and the meeting of any other health need not being met by any other organization in the community. The Red Cross always works to the end that the work it is doing shall at the proper time be taken over by the official agency whose function it is eventually to do that work.

The public health nurses of the Red Cross, of whom 1,267 were employed by chapters in 1,240 different places on July 1, 1921, are at work in all parts of the country. They are found in the high places of the Sierras, on the plains of New Mexico, the Indian reservations, among the negroes of the lowlands of the Gulf States, in the mountains of Kentucky and Tennessee, the forests of the Northern States, and on the lonely islands of the New England coast, as well as throughout the towns and villages of the country.

All this work, in addition to the First Aid and Disaster Relief Work and the Nutrition Service, is a part of the peace-time program of the Red Cross. Moreover, many of its war obligations are still unfulfilled. Most important of these is care of the disabled ex-service men. The Red Cross expenditures for the disabled men are running at the rate of $10,000,000 a year. And the number of these men has not yet reached its peak. Through its Fifth Annual Roll Call, to be held November 11-24 of this year, the Red Cross hopes greatly to increase its membership in order that the work may be continued at a high level of efficiency.

TO STUDY HOSPITAL ADMINISTRATION

The Rockefeller Foundation desiring to promote medical education and public health on an international basis and believing that trained leadership is essential to sound progress provides fellowships to promising medical men from various countries. Eight physicians from Czecho-Slovakia and three from Poland have just arrived in New York for a period of research and study under such fellowships. The men have been selected on the basis of qualification to pursue advanced courses in preparation for institutional or government service later in their own countries, either as teachers, investigators or administrators. One of the physicians, Dr. Jan Surawski, of Poland, will make a special study of hospital administration and schools for training of bedside and public health nurses. Dr. Surawski is a graduate of the medical faculty of the University of Zurich. After practicing medicine for a period of years, he became a health officer and later a hospital inspector. At present he is assistant in the Bureau of Hospitals in the Polish Ministry of Health and will return to the Ministry of Health to take charge of the Divisions of Hospitals.

PLAN TO HAVE FOUR YEAR COURSE

A four year course in medicine is to be established at the University of Missouri, according to an announcement by the board of curators. The course has consisted of two years in the past, but it will be increased as soon as hospital facilities are available for clinical work. The legislature has appropriated $250,000 for the establishment of a state hospital at Columbia for the purpose of providing the clinical material for the students. A similar sum will probably be appropriated at each session of the legislature until $1,000,000 is available.

LIBRARY RECEIVES GIFTS

Three interesting books have recently been presented to the Hospital Library and Service Bureau. The third edition of "Notes on Hospitals," by Florence Nightingale, published in 1863, was presented by Mr. Richard E. Schmidt of Chicago. Mr. Daniel D. Test, superintendent of Pennsylvania Hospital, Philadelphia, Pa., sent the library a copy of the "History of the Pennsylvania Hospital from 1751-1895," and Dr. J. J. Dowling, superintendent of the Boston City Hospital, sent a copy of the "History of the Boston City Hospital from 1864-1904."

The MODERN HOSPITAL

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HOSPITAL RULES AND REGULATIONS

THE rules and regulations of a hospital are not given the thought they deserve. Administrators are very prone to be governed by their own viewpoint and their own convenience and not to consult the patient or public.

Business men soon learn to conduct their stores and offices to meet the whims and desires of their customers. Trade goes to the place where, others things being equal, it is made easiest to trade. This is a subtle element in the success of a business enterprise and its head may be wholly unconscious that his rules and regulations are a big factor in drawing trade.

Hospitals are not competitive. They are not compelled to study this phase of their every day routine in order to get or to retain custom. As a rule they are crowded and it is a matter of indifference to them whether patrons are satisfied or not, provided the outcome of the case has been a cure. If the patient leaves relieved or restored, he ought to be satisfied and frequently is.

But it is a serious question whether the institution should regard that as complete fulfillment of obligation.

The modern hospital knows that a comfortable feeling on the part of the patient is a physiological factor toward a favorable end. What part do the rules and regulations play in this element we call "comfortable feeling"? This is a question which hospital administrators are called upon to consider. They must forget they are not seeking trade in competition with others. Rules of conduct for patients, employees and visitors are not with the hospital what they are with the merchant. He has a selfish motive. The hospital has the unselfish interest of its patients at heart. Hospital discipline is often unnecessarily harsh, petty, pedantic, chaffing employees and irritating both patient and public, when it might just as well be mild or so soft as not to be felt.

It seems to be easy for a physician to become a martinet. Often this type is found at the head of a hospital. Not only is his personality objectionable to employees and patrons but his rules and discipline, being a reflection of his small character, render the institution almost unbearable with their very pettiness and flavor of small tyranny.

This class of professional administrator is often discovered in charge of publicly or tax supported institutions. The military officer, accustomed to the imposition of severe discipline, forgets, when he becomes manager of a hospital, that he is dealing with a different situation. Political doctors, of inconsequential proportions, are elevated to superintendencies of great institutions and there develop a new character. Feeling their authority and being without the balance wheel of experience in large affairs, they soon begin to inflict penalities and devise stiff regulations as the cure-all for real or imaginary defects in their organization, wholly oblivious to the fact that they and not rules or absence of rules are responsible for inharmonious relations and failures.

Good order among employees, loyal support by them of hospital policies and aims, smooth operation, contentment of patients and public will be found where morale has sprung from mutual interest and the spirit to serve. Rules and regulations of themselves never produce morale nor create a spirit, but a few necessary rules develop and grow, naturally as it were, from this morale and spirit to serve. A hospital that has these two elements working for it is little worried about rules and regulations. Where these elements are absent, the superintendent and trustees will surely be found trying to devise substitutes in the form of a book of rules. Whenever an institution is governed from an elaborate rule book, or new regulations are issued daily from headquarters, one may be sure that something fundamental is wrong.

To paraphrase an old saying about government, the best hospital is the least governed hospital.

HOSPITAL LABOR PROBLEMS

RECONSTRUCTION as it is affected by labor seriously troubles hospitals. The public is demanding a higher standard of service in the hospitals because it is paying a higher price. It overlooks the fact that the higher price is to cover the higher cost of the former service. Higher prices are charged and collected for every service and commodity the public needs, but it does not demand any better for the higher price. When it buys hospital service, however, it wants more service in proportion with the higher price.

Labor is a material factor in increasing the cost of hospital service. Labor, as we use the term, includes both the salary and the wage classes.

First: It is necessary to convince the public that hospital operation has gone up like everything else man needs, and better service than formerly was given cannot be furnished on present schedules. This a subject for propaganda.

Second: Hospitals will have to study the methods of commercial and manufacturing businesses in curtailing labor. Introduction of labor-saving devices must follow. Consideration of this matter has not developed in hospitals because until recently they have been able to get help at small wages and long hours. This is not possible now. Hospitals face the eight hour day and must get ready for it.

Third: The shortage of registered nurses and of pupils in training is a serious handicap. It means a reorganization of internal management and the training of the registered nurse to perform a greater and more skillful supervisory and administrative function on the same energy. A class to be known as attendants who neither are pupils nor are likely to be, can be trained to do much of the work that has fallen upon the registered nurse or the advanced pupil.

Fourth: In hospital planning and construction architects and hospital administrators may incorporate many labor-saving devices, that will eliminate steps and waits and, at the same time, make the supervision of employees and service easy and more effective. The relation between emergency service, dispensary service and the methods of large industry incorporated in their factories and offices to save time and the physical strength of employees, to provide supervision at the least possible cost and to eliminate items of expense, both little and big, will bear study by the hospital planner.

Fifth: Dispensary and out-patient service, improved and extended, and earlier detection and diagnosis through the means of public health agencies together will serve to reduce the demands on the hospital.

Altogether the readjustment of hospital and labor involves as many knotty problems as may be found in any industrial or mercantile enterprise, but it will be easier in the latter than in the former. It is the serious duty of every hospital man and woman to give the problem close thought and to contribute his ideas to the benefit of all.

DISCOUNTS AS DONATIONS

IN AN effort to economize, some hospitals make it a practice to ask jobbers and wholesalers with whom they deal to discount their regular prices from time to time, and to regard these discounts as in the nature of donations to the institution. Commendable as is every legitimate effort to economize, this method does not commend itself to us. To institutions that are importunate enough, manufacturers will occasionally reluctantly grant the discounts, and hospitals here and there may seemingly profit by such practices. By and large, however, these donations will be added to selling costs, and ultimately find their way into the prices charged the hospital field at large.

1921 LIST SHOWS MANY ADDITIONS

THE American College of Surgeons' 1921 list of approved hospitals, which was made public at the Clinical Congress held at Philadelphia on October 24, 1921, shows that the College has made considerable headway with its program of minimum standards since the publication of its 1920 list. (See THE MODERN HOSPITAL, November, 1920, page 420.) These lists, we need hardly remind our readers, apply thus far only to general hospitals of 100 or more beds, in the United States and Canada. The 1920 list, as finally compiled, contains 407 hospitals out of a group of 695; the 1921 list contains 564, or 74 per cent of the 761 general hospitals. This represents a gain of 176 hospitals during the past year. In 1918 only eighty-nine general hospitals of 100 or more beds met the standards, while in 1919 there were 198. In this connection it is interesting to note that 176, or 25 per cent of the 704 general hospitals of fifty to 100 beds visited by representatives of the College during the past two years, have also met the minimum standard. A list of the institutions in this group which met the College's requirements will be published next year.

This progress indicates not only that the minimum standards, as formulated by the College, are practicable, but that there is an increasing desire on the part of our hospitals to qualify for efficient service to their patients.

But what of the 197 hospitals of 100 beds and

more that are not yet included in the list? In few, if any, instances is their absence from the list due to lack of funds. In some cases it is due to the unethical practice of fee splitting among the medical staff. In the main, however, it is due to an inadequate record system and the lack of a regular, periodical review of the professional work of the medical staffs, and this in turn is due fundamentally to the absence of adequate hospital organization.

This problem, however, is not an unsolvable one, and we look to see the 1922 list of the College contain 90 per cent or more of the hospitals of 100 or more beds. A list containing all of the hospitals of this group, though scarcely to be looked for in the very near future, would certainly reflect great credit upon their enterprise and good faith.

STEEPLE JACKS

ACROSS from my office window is a massive building. On the corner of the building is a round, dome-like tower. On the lower edge of that tower at this moment is a boy perilously near to vacant space brushing the side of the tower. He is whistling nonchalantly as he works, now and then craning his neck over the edge to see what is going on in the street below. My heart stands still as I watch him!

Involuntarily I ask myself, "Why is he doing that? Why is he risking his life so unconcernedly? Why hasn't he one of those belts, which at least look efficient, around his waist?" Well—I suppose he is doing that because it is his job. We are all in the same boat—society's—and only if each one of us does his amount of rowing will the boat move forward. And he is doing his rowing so gaily, without a thought of "This is pretty dangerous business, I think I ought to have some safety apparatus.

He ought to have the safety belt, yes, anyone will agree to that, but he hasn't, and yet he goes ahead with his work quite as faithfully as if he had. We haven't all of us ideal working conditions or all the equipment we may desire, but are we going ahead gaily without self-pity, using every bit of our energy and resource, both material and spiritual, in doing our job?

Mr. Galsworthy, in the October issue of *The Yale Review*, says that this is an age of "camouflaged commercialism, wherein to do things well, *for the joy of doing them well*, is rarer than we think."

Then he goes on to say, "But let us give the devil its due. Let us admit at once that in spite of everything this is still the best age, on the whole, that man has lived in. It is in its own way very thorough—our modern civilization. It has made advertisement into a fine art, equipped bedrooms with telephones; it diagnoses maladies with extreme punctilio. A doctor examined a young lady the other day, and among his notes were these: 'Not afraid of small rooms, ghosts, or thunderstorms; not made drunk by hearing Wagner; brown hair, artistic hands; had a craving for chocolate in 1918.' "

But there is a kind of "deadly practicality" about this thoroughness, says Mr. Galsworthy. He is arguing for the cult of beauty, which he defines in what seems to me a strikingly fine way, as "a higher and wider conception of the dignity of human life." Hospitals, I believe, more than any other institution today, have within their grasp the opportunity to dignify human life. That is one of the largest parts of their social rowing—will they do it?

PSYCHOPATHIC WARD FOR CHILDREN

THE account of the Cleveland Babies' and Children's Hospital in the September number of the MODERN HOSPITAL (p. 187), is interesting from two angles. First, splendid provision has been made for research and study. Second, there is a psychopathic ward, but very striking is the small space devoted to its description. We hope that it is not to be so insignificant in practice.

A hospital which is to serve the purpose for which this one has been planned will receive children, a large proportion of whom should be observed and studied for mental deficiencies or obliquities. Children, for instance, who have been born in poverty are not necessarily psychopathic but, in the modern conception of things, poverty is not conducive either to mental or physical health. The conditions of poverty which will bring many children into this hospital for physical treatment are likely to be responsible for mental troubles, not yet discernible except by the trained and experienced expert in mental diseases.

Children born into the world crippled and deformed may be mentally at par, but a study of them and of their heredity and environment is just as essential to their future as are the study and correction of their physical defects.

Any institution, public or private, which specializes in children's diseases, is performing only part of its mission when it applies itself to the physical being alone and neglects the mental, because, perhaps, there has developed nothing the naked eye can see.

We take it that the elaborate provision made in this institution for research has included a liberal and very generous use of the psychopathic ward.

HOSPITAL STANDARDIZATION MAKES HEADWAY*

SINCE the inception of the movement for the standardization of hospitals by the American College of Surgeons in 1915, and after the minimum standard was evolved from the combined experience of surgeons, internists, and hospital executives, it has met with increasing recognition, until today 74 per cent of the hundred bed hospitals in the United States and Canada have adopted it.

Surely, the time for debate has passed. It is beside the mark to argue the wisdom of a movement which has enlisted the cooperation of three-fourths of hospital America. Any advance in medicine must begin—and end—with the welfare of the patient. He must be at once the actuating impulse and the final beneficiary. Just so surely as the patient is benefited, so also will be the doctor and the hospital. And, precisely, because the minimum standard was evolved to bring every group in the hospital together to work for the patient, it created an organization which resulted in better work for the individual surgeon, internist, hospital superintendent, and nurse.

The minimum standard embodies the basic principles of scientific research. Research begins with securing facts, compiling facts, analyzing facts. This done, research draws tentative conclusions gained from analysis of the facts. These conclusions, if supported by sufficient evidence and corroborated by practice, become known as scientific truths.

This standard consists of a working arrangement by which these same principles of research are applied daily in the hospital for the benefit of the patient. Accurate, adequate case records, modern laboratory equipment manned by skilled technicians—what are these but provisions to marshal the facts before the physician for examination? The monthly clinical staff meeting—what is this but an opportunity to test out the data which the records and laboratories have furnished? Insistence on competent and ethical practitioners—what is this but insurance that the interpreters of the facts regarding each patient are skilled medical men, on whose judgment the public has every right to rely? The working formula for this program is the minimum standard.

The minimum standard is, in essence, an arrangement by which the hospital can insure its patients the best care known to the science of medicine. We have shown how it provides an application of the principles of scientific research to the care of the patient—the same principles which the individual doctor or surgeon uses for arriving at a diagnosis. And because medical men the country over were quick to see not only the practical but the scientific basis underlying the minimum standard, they have given it, in increasing numbers, their unqualified support.

It is easy to devise a system of rules which—on paper—is perfect. It is quite another matter to evolve a standard of such simplicity that it stands the test of actual conditions in hospital work. Whether the minimum standard is eminently practicable in the every day administration of hospitals is best answered by the following report:

The Acceptance of the Program

In 1918, of the general hospitals of one hundred or more beds in the United States and Canada, eighty-nine met the standard. In 1919, 198 fulfilled the requirements; in 1920 407 or 57 per cent, met the standard; and this year 564 or 74 per cent of the 761 general hospitals are on the "approved" list.

Further, what has been the experience of other organizations interested in hospital betterment? Manifestly, their reaction toward the program furnishes another reliable index as to its applicability. A decided impetus has been given to hospital standardization by the acceptance and endorsement of the minimum standard by such influential and powerful organizations as the American Hospital Association, the Canadian Medical Association, the Catholic Hospital Association, the Conference Board of Hospitals and Homes of the Methodist Church, the Medical and Surgical Section of the American Railway Association, the Methodist Hospital Association, the Protestant Hospital Association, and numerous state, provincial, and local organizations.

The Method and Scope of the Work

The hospital surveys of the College are conducted through a trained corps of hospital visitors, all of whom are graduates in medicine. Their purpose is to explain the minimum standard, to interpret its application to each hospital, and to offer constructive criticism and helpful suggestions to remedy any existent shortcomings. Upon these detailed personal surveys, the College is dependent for an accurate estimate of each hospital's status relative to the minimum standard.

An important adjunct to the work of the hospital surveyors has been the emphasis placed on hospital standardization at the state and provincial sectional meetings of the College. At these meetings conferences are held which are devoted to a discussion of pertinent hospital problems by those intimately connected with hospitals. In addition, the community interest is stimulated at public meetings where the benefits of hospital standardization are portrayed.

In 1920, the general hospitals of one hundred or more beds in the United States and Canada were visited. A complete report of last year's survey is contained in bulletin No. 1, Vol. 5, issued by the College in January, 1921. This year particular attention has been directed toward those hospitals which in 1920 either were not included in the list, or which were listed with an asterisk. Hospitals which were fully approved in 1920 were not as a routine visited this year, although in all probability visits to these institutions will be resumed in the future.

In addition, 704 general hospitals of fifty to one hundred beds were visited during the past two years, 306 in 1920 and 398 in 1921. As there are approximately 854 of these smaller hospitals in the United States and Canada, 150 remain to be visited. Of these 704 visited during 1920 and 1921, 176, or 25 per cent, of the total number met the standard. The individual listing of this group of institutions will appear next year.

The Program for the Future

Consequently, the survey of 1922 will be extended to include all general hospitals of fifty beds and over in the United States and Canada. Of these institutions already visited, many showed a working knowledge of the minimum standard and evinced an active desire to cooperate. The percentage of these meeting the standard at their first visit compares favorably with the percentage of hundred bed hospitals which were approved on their first inspection. If proof were needed of the universal appli-

*From a report of the American College of Surgeons' Survey of Hospitals for 1921, read at the Clinical Congress in Philadelphia on Oct. 24, 1921.

cation of the minimum standard, the acceptance by the smaller hospitals would furnish it. Stressing only broad fundamentals, the minimum standard moulds itself to meet specific needs, nowhere impeding initiative, or fettering judgment. Rightly conceived and carried out, it makes the hospital the proved guardian of the community health, rendering scientific service to all.

Capacity of 100 Beds and Over

The following list contains the names of those general hospitals of one hundred or more beds, in the United States and Canada, which meet the minimum standard. In this list a certain number of the institutions are designated with an asterisk. This group includes those hospitals which, when visited, had adopted the fundamental principles of the minimum standard, but which at that time had not had sufficient opportunity to develop all of them to a degree meriting the fullest approval. The hospitals listed without an asterisk, having instituted these measures at an earlier date, had received the benefits of a longer experience in the workings of the program and consequently a broader conception of its application.

UNITED STATES[1]

ALABAMA

Employees Hospital, T. C. I. & R. R. Co., Birmingham
*Hillman Hospital, Birmingham
Mobile City Hospital, Mobile
Southb Highlands Infirmary, Birmingham

ARKANSAS

*Logan H. Roots Memorial Hospital, Little Rock
St. Louis Southwestern Hospital, Texarkana
St. Vincent's Hospital, Little Rock

CALIFORNIA

Alameda County Hospital, San Leandro
Children's Hospital, San Francisco
*Franklin Hospital, San Francisco
*French Hospital, San Francisco
*Hospital of the Good Samaritan, Los Angeles
Lane Hospital, San Francisco
Los Angeles County Hospital, Los Angeles
Mary's Help Hospital, San Francisco
Mt. Zion Hospital, San Francisco
*O'Connor Sanitarium, San Jose
Pasadena Hospital, Pasadena
*Providence Hospital, Oakland
St. Francis' Hospital, San Francisco
St. Joseph's Hospital, San Francisco
St. Joseph's Sanitarium, San Diego
*St. Luke's Hospital, San Francisco
St. Mary's Hospital, San Francisco
St. Vincent's Hospital, Los Angeles
San Diego County Hospital, San Diego
San Francisco Hospital, San Francisco
*San Joaquin County Hospital, French Camp
Santa Barbara Cottage Hospital, Santa Barbara
Santa Clara County Hospital, San Jose
Santa Fe Coast Lines Hospital, Los Angeles
Southern Pacific Hospital, San Francisco
*Stanford Hospital, San Francisco
University of California Hospital, San Francisco
White Memorial Hospital, Los Angeles

COLORADO

*Denver City and County Hospital, Denver
Glockner Sanatorium and Hospital, Colorado Springs
*Mercy Hospital, Denver
Minnequa Hospital, Pueblo
St. Anthony's Hospital, Denver
*St. Francis' Hospital, Colorado Springs
*St. Mary's Hospital, Pueblo

CONNECTICUT

Bridgeport Hospital, Bridgeport
Grace Hospital, New Haven
Greenwich General Hospital, Greenwich
Hartford Hospital, Hartford
Lawrence and Memorial Associated Hospitals, New London
New Haven Hospital, New Haven
St. Francis' Hospital, Hartford
St. Mary's Hospital, Waterbury
St. Vincent's Hospital, Bridgeport
*Stamford Hospital, Stamford
Waterbury Hospital, Waterbury

DELAWARE

Delaware Hospital, Wilmington

DISTRICT OF COLUMBIA

Central Dispensary and Emergency Hospital, Washington
Children's Hospital, Washington
Columbia Hospital for Women, Washington
Freedman's Hospital, Washington
Garfield Memorial Hospital, Washington
George Washington University Hospital, Washington
Georgetown University Hospital, Washington
Providence Hospital, Washington
*Washington Sanitarium, Washington

GEORGIA

Georgia Baptist Hospital, Atlanta
Grady Memorial Hospital, Atlanta
University Hospital, Augusta

IDAHO

St. Alphonsus Hospital, Boise

ILLINOIS

Alexian Brothers' Hospital, Chicago
*American Hospital, Chicago
Augustana Hospital, Chicago
Chicago Lying-In Hospital, Chicago
Children's Memorial Hospital, Chicago
Columbus Hospital, Chicago
Cook County Hospital, Chicago
Evanston Hospital, Evanston
*Frances E. Willard Hospital, Chicago
Grant Hospital, Chicago
Hahnemann Hospital, Chicago
Illinois Central Hospital, Chicago
*Illinois Charitable Eye and Ear Infirmary, Chicago
*John C. Proctor Hospital, Peoria
Mercy Hospital, Chicago
Michael Reese Hospital, Chicago
Presbyterian Hospital, Chicago
Rockford Hospital, Rockford
St. Anne's Hospital, Chicago
St. Bernard's Hospital, Chicago
*St. Elizabeth's Hospital, Chicago
*St. Elizabeth's Hospital, Danville
St. Francis' Hospital, Blue Island
*St. Francis' Hospital, Evanston
*St. Francis' Hospital, Peoria
St. Joseph's Hospital, Chicago
St. Luke's Hospital, Chicago
*St. Mary's Hospital, Cairo
*St. Mary's Hospital, East St. Louis
St. Mary's Hospital, La Salle
St. Mary of Nazareth Hospital, Chicago
*St. Vincent's Hospital, Belleville
South Shore Hospital, Chicago
Swedish Covenant Hospital, Chicago
Wesley Memorial Hospital, Chicago

INDIANA

Indianapolis City Hospital, Indianapolis
Methodist Episcopal Hospital, Indianapolis
Robert W Long Hospital, Indianapolis
St. Anthony's Hospital, Terre Haute
St. Elizabeth's Hospital, LaFayette
St. Joseph's Hospital, Fort Wayne
St. Margaret's Hospital, Hammond
St. Mary's Hospital, Evansville
St. Mary's Mercy Hospital, Gary
St. Vincent's Hospital, Indianapolis

IOWA

Finley Hospital, Dubuque
Iowa Lutheran Hospital, Des Moines
Jennie Edmundson Hospital, Council Bluffs
Mercy Hospital, Council Bluffs
Mercy Hospital, Davenport
*Mercy Hospital, Des Moines
St. Francis' Hospital, Waterloo
St. Joseph's Mercy Hospital, Dubuque
St. Joseph's Mercy Hospital, Sioux City
St. Vincent's Hospital, Sioux City
University Hospital, Iowa City

KANSAS

*Bethany Methodist Hospital, Kansas City
St. Francis' Hospital, Wichita
St. Margaret's Hospital, Kansas City

KENTUCKY

Good Samaritan Hospital, Lexington
Louisville City Hospital, Louisville
Norton Memorial Infirmary, Louisville
St. Anthony's Hospital, Louisville
*St. Elizabeth's Hospital, Covington
Sts. Elizabeth and Mary Hospital, Louisville
St. Joseph's Hospital, Lexington
St. Joseph's Infirmary, Louisville

LOUISIANA

Charity Hospital, New Orleans
*Hotel Dieu, New Orleans
St. Francis Hospital, Monroe
T. E. Schumpert Memorial Hospital, Shreveport
Touro Infirmary, New Orleans

MAINE

Eastern Maine General Hospital, Bangor
*St. Mary's General Hospital, Lewiston

MARYLAND

Bay View City Hospital, Baltimore
Church Home and Infirmary, Baltimore
*Franklin Square Hospital, Baltimore
Hebrew Hospital and Asylum, Baltimore
Hospital for Women of Maryland, Baltimore
Johns Hopkins Hospital, Baltimore
Maryland General Hospital, Baltimore
Mercy Hospital, Baltimore
Morrow Hospital, Baltimore
St. Agnes' Hospital, Baltimore
St. Joseph's Hospital, Baltimore.
Union Memorial Hospital, Baltimore
University Hospital, Baltimore.

MASSACHUSETTS

Boston City Hospital, Boston
Brockton Hospital, Brockton
Burbank Hospital, Fitchburg
Cambridge City Hospital, Cambridge
Carney Hospital, Boston
Children's Hospital, Boston
City Hospital, Fall River
*Cooley-Dickinson Hospital, Northampton
Holyoke City Hospital, Holyoke
Lawrence General Hospital, Lawrence
Long Island Hospital, Boston
Lowell Corporation Hospital, Lowell
Lowell General Hospital, Lowell
Lynn Hospital, Lynn
Massachusetts General Hospital, Boston
Massachusetts Homeopathic Hospital, Boston
Memorial Hospital, Worcester
Mercy Hospital, Springfield
New England Hospital for Women and Children, Boston
Newton Hospital, Newton Lower Falls
Peter Brent Brigham Hospital, Boston
Providence Hospital, Holyoke
St. Elizabeth's Hospital, Boston
St. John's Hospital, Lowell
*St. Luke's Hospital, New Bedford
St. Vincent's Hospital, Worcester
Salem Hospital, Salem
Springfield Hospital, Springfield
Union Hospital, Fall River
Worcester City Hospital, Worcester

MICHIGAN

Battle Creek Sanitarium, Battle Creek
Blodgett Memorial Hospital, Grand Rapids
Butterworth Hospital, Grand Rapids
Children's Free Hospital, Detroit
Detroit Receiving Hospital, Detroit
Grace Hospital, Detroit
Harper Hospital, Detroit
Hackley Hospital, Muskegon
Henry Ford Hospital, Detroit
Highland Park General Hospital, Highland Park
House of Providence, Detroit
St. Joseph's Hospital, Ann Arbor
St. Mary's Hospital, Grand Rapids
St. Mary's Hospital, Detroit
University Hospital, Ann Arbor
University of Michigan Homeopathic Hospital Ann Arbor
Woman's Hospital and Infant's Home, Detroit

MINNESOTA

Bethesda Hospital, St. Paul
City and County Hospital, St. Paul
Colonial Hospital, Rochester
Deaconess Hospital, Minneapolis
*Eitel Hospital, Minneapolis
*Fairview Hospital, Minneapolis
Minneapolis General Hospital, Minneapolis
Mounds Park Sanitarium, St. Paul
St. Joseph's Hospital, St. Paul
*St. Luke's Hospital, St. Paul
St. Mary's Hospital, Duluth
St. Mary's Hospital, Minneapolis
St. Mary's Hospital, Rochester.
*St. Paul Hospital, St. Paul
*Swedish Hospital, Minneapolis
University of Minnesota Hospital, Minneapolis
Worrell Hospital, Rochester

MISSISSIPPI

Matty Hersee Hospital, Meridian

MISSOURI

Alexian Brothers' Hospital, St. Louis
Barnes Hospital, St. Louis
Children's Hospital, Kansas City.

[1]This is complete only to October 4, when the American College of Surgeons' report went to press.

*Christian Church Hospital, Kansas City
*Evangelical Deaconess Home and Hospital, St. Louis
Jewish Hospital, St. Louis
Kansas City General Hospital, Kansas City
Lutheran Hospital, St. Louis
*Mullanphy Hospital, St. Louis
Research Hospital, Kansas City
St. Athony's Hospital, St. Louis
St. John's Hospital, St. Louis
St. Joseph's Hospital, Kansas City
St. Louis Children's Hospital, St. Louis
St. Louis City Hospital, St. Louis
St. Luke's Hospital, St. Louis
St. Mary's Hospital, Kansas City
St. Mary's Infirmary, St. Louis

MONTANA

Columbus Hospital, Great Falls
Montana Deaconess Hospital, Great Falls
Murray Hospital, Butte
St. James' Hospital, Butte
St. Patrick's Hospital, Missoula

NEBRASKA

*Nebraska Methodist Hospital, Omaha
*Nebraska Orthopedic Hospital and Home, Lincoln
St. Elizabeth's Hospital, Lincoln
St. Francis' Hospital, Grand Island
St. Joseph's Hospital, Omaha
*St. Mary's Hospital, Columbus
University of Nebraska Hospital, Omaha

NEW HAMPSHIRE

St. Joseph's Hospital, Nashua

NEW JERSEY

*Alexian Brothers Hospital, Elizabeth
Atlantic City Hospital, Atlantic City
Bayonne Hospital and Dispensary, Bayonne
Christ Hospital, Jersey City
Cooper Hospital, Camden
Elizabeth General Hospital, Elizabeth
Hackensack Hospital, Hackensack
Jersey City Hospital, Jersey City
Mercer Hospital, Trenton
Monmouth Memorial Hospital, Long Branch
Morristown Memorial Hospital, Morristown
Mountainside Hospital, Montclair
Muhlenberg Hospital, Plainfield
Newark Beth Israel Hospital, Newark
Newark City Hospital, Newark
Newmark Memorial Hospital, Newmark
Orange Memorial Hospital, Orange
Passaic General Hospital, Passaic
Paterson General Hospital, Paterson
St. Elizabeth's Hospital, Elizabeth
St. Francis' Hospital, Trenton
*St. Joseph's Hospital, Paterson
*St. Mary's Hospital, Hoboken
*St. Michael's Hospital, Newark

NEW YORK

Albany Hospital, Albany
Bellevue Hospital, New York
Beth Israel Hospital, New York
Beth Moses Hospital, Brooklyn
*Binghamton City Hospital, Binghamton
Broad Street Hospital, New York
Brooklyn Hospital, Brooklyn
Brownsville and East New York Hospital, Brooklyn
Buffalo City Hospital, Buffalo
Buffalo General Hospital, Buffalo
*Buffalo Homeopathic Hospital, Buffalo
*Buffalo Hospital of Sisters of Charity, Buffalo
*Bushwick Hospital, Brooklyn
Carson C. Peck Memorial Hospital, Brooklyn
*Children's Hospital, Buffalo
Clifton Springs Sanitarium, Clifton Springs
Community Hospital, New York
Coney Island Hospital, Brooklyn
*Crouse-Irving Hospital, Syracuse
Cumberland Street Hospital, Brooklyn
Ellis Hospital, Schnectady
*Flower Hospital, New York
Flushing Hospital and Dispensary, Flushing
Fordham Hospital, New York
French Benevolent Hospital, New York
*Good Shepherd Hospital, Syracuse
Gouverneur Hospital, New York
Greenpoint Hospital, Brooklyn
Hahnemann Hospital, New York
Hahnemann Hospital, Rochester
Harlem Hospital, New York
Holy Family Hospital, Brooklyn
Homeopathic Hospital, Albany
Jewish Hospital, Brooklyn
Kings County Hospital, Brooklyn
Lehanon Hospital, New York
*Lenox Hill Hospital, New York
Lincoln Hospital, New York
Long Island College Hospital, Brooklyn
*Manhattan Eye and Ear Hospital, New York
Memorial Hospital, New York
Methodist Episcopal Hospital, Brooklyn
Metropolitan Hospital, New York
Misericordia Hospital, New York
Mount St. Mary's Hospital, Niagara Falls
Mount Sinai Hospital, New York
*Mount Vernon Hospital, Mount Vernon
New York City Hospital, Blackwell's Island, New York
*New York Eye and Ear Infirmary, New York
*New York Foundling Home, New York
New York Hospital, New York
New York Infirmary for Women and Children, New York
New York Nursery and Children's Hospital, New York
New York Orthopedic Hospital, New York
New York Post-Graduate Hospital, New York
New York Hospital for Ruptured and Crippled, New York
New York Skin and Cancer Hospital, New York
*New York State Hospital for Crippled Children, West Haverstraw
*Niagara Falls Memorial Hospital, Niagara Falls
Norwegian Lutheran Deaconess Hospital, Brooklyn
*Oneida County Hospital, Rome
Presbyterian Hospital, New York
Rochester General Hospital, Rochester
Rochester Homeopathic Hospital, Rochester
Roosevelt Hospital, New York
St. Catherine's Hospital, Brooklyn
St. Francis Hospital, New York
St. John's Brooklyn Hospital, Brooklyn.
St. John's Hospital, Long Island
St. John's Riverside Hospital, Yonkers
*St. Joseph's Syracuse Hospital, Syracuse
St. Luke's Hospital, New York
St. Mark's Hospital, New York
St. Mary's Free Hospital for Children, New York
St. Mary's Hospital, Brooklyn
*St. Mary's Hospital, Rochester
*St. Peter's Hospital, Albany
*St. Peter's Hospital, Brooklyn
St. Vincent's Hospital, New York.
Samaritan Hospital, Troy
Sloane Hospital for Women, New York
Staten Island Hospital, Tompkinsville
Syracuse Memorial Hospital, Syracuse
Troy Hospital, Troy
Woman's Hospital, New York
Wyckoff Heights Hospital, Brooklyn
*Yonkers Homeopathic Hosptial, Yonkers

NORTH CAROLINA

*Watts Hospital, West Durham

NORTH DAKOTA

Bismarck Evangelical Deaconess Hospital, Bismarck
*Grand Forks Deaconess Hospital, Grand Forks
St. Alexius' Hospital, Bismarck
St. John's Hospital, Fargo
St. Luke's Hospital, Fargo

OHIO

*Aultman Hospital, Canton
Bethesda Hospital, Cincinnati
Christ Hospital, Cincinnati
Cincinnati General Hospital, Cincinnati
City Hospital of Akron, Akron
Cleveland City Hospital, Cleveland
Good Samaritan Hospital, Cincinnati
Good Samaritan Hospital, Zanesville
Grant Hospital, Columbus
Hawkes Hospital of Mount Carmel, Columbus
Jewish Hospital, Cincinnati
Lakeside Hospital, Cleveland
Miami Valley Hospital, Dayton
*Mercy Hospital, Hamilton
Mount Sinai Hospital, Cleveland
*Peoples Hospital, Akron
*Protestant Hospital Association, Columbus
St. Alexis' Hospital, Cleveland
St. Elizabeth's Hospital, Youngstown
St. Francis' Hospital, Columbus
St. John's Hospital, Cleveland
*St. Luke's Hospital, Cleveland
St. Mary's Hospital, Cincinnati
St. Rita's Hospital, Lima
St. Vincent's Hospital, Cleveland
St. Vincent's Hospital, Toledo
Springfield City Hospital, Springfield
Toledo Hospital, Toledo
*Youngstown Hospital, Youngstown

OKLAHOMA

St. Anthony's Hospital, Oklahoma
State University Hospital, Oklahoma

OREGON

Emanuel Hospital, Portland
St. Vincent's Hospital, Portland

PENNSYLVANIA

Allegheny General Hospital, Pittsburgh
Allentown Hospital, Allentown
Altoona Hospital, Altoona
Braddock General Hospital, Braddock
Chester County Hospital, West Chester
Chester Hospital, Chester
Children's Homeopathic Hospital, Philadelphia
Clearfield Hospital, Clearfield
Columbia Hospital, Pittsburgh
Conemaugh Valley Memorial Hospital, Johnstown
*Elizabeth Steel Magee Hospital, Pittsburgh
Easton Hospital, Easton
Frankford Hospital, Philadelphia
George F. Geisinger Hospital, Danville
Germantown Dispensary and Hospital, Philadelphia
Hahnemann Medical College Hospital, Philadelphia
*Hamot Hospital, Erie
Harrisburg Hospital, Harrisburg
Homeopathic Medical and Surgical Hospital, Pittsburgh
Hospital of the Protestant Episcopal Church, Philadelphia
Hospital of the University of Pennsylvania, Philadelphia
Hospital of the Women's Medical College, Philadelphia
Jefferson Medical College Hospital, Philadelphia
Jewish Hospital, Philadelphia
Lancaster General Hospital, Lancaster
Lankenau Hospital, Philadelphia
*Medical, Surgical, and Maternity Hospital of the Women's Homeopathic Association, Philadelphia
Medico-Chirurgical Hospital, Philadelphia
*Memorial Hospital, Philadelphia
Mercy Hospital, Johnstown
Mercy Hospital, Pittsburgh
Mercy Hospital, Wilkes-Barre
Methodist Episcopal Hospital, Philadelphia
Misericordia Hospital, Philadelphia
Moses Taylor Hospital, Scranton
Passavant Hospital, Pittsburgh
Pennsylvania Hospital, Philadelphia
Philadelphia General Hospital, Philadelphia
Philadelphia Polyclinic Hospital, Philadelphia
Pittsburgh Hospital, Pittsburgh
Pottsville Hospital, Pottsville
Presbyterian Hospital, Philadelphia
Presbyterian Hospital Pittsburgh
Reading Hospital, Reading
*Robert Packer Hospital, Sayre
Sacred Heart Hospital, Allentown
St. Agnes' Hospital, Philadelphia
St. Francis' Hospital, Pittsburgh
*St. John's General Hospital, Pittsburgh
*St. Joseph's Hospital, Lancaster
St. Joseph's Hospital, Philadelphia
St. Joseph's Hospital, Pittsburgh
St. Luke's Hospital, South Bethlehem
St. Margaret's Hospital, Pittsburgh
St. Mary's Hospital, Philadelphia
St. Vincent's Hospital, Erie
Samaritan Hospital, Philadelphia
South Side Hospital, Pittsburgh
*State Hospital for Injured Persons, Ashland
State Hospital for the Middle Coal Fields, Hazelton
*State Hospital of the Northern Anthracite Coal Regions, Scranton
*Western Pennsylvania Hospital, Pittsburgh
Wilkes-Barre City Hospital, Wilkes-Barre
Wills Hospital, Philadelphia
Woman's Hospital, Philadelphia
York Hospital and Dispensary, York

RHODE ISLAND

Rhode Island Hospital, Providence
St. Joseph's Hospital, Providence

SOUTH CAROLINA

Chick Springs Sanitarium, Chick Springs
Florence Infirmary, Florence
Roper Hospital, Charleston

SOUTH DAKOTA

McKennan Hospital, Sioux Falls
*St. Luke's Hospital, Aberdeen

TENNESSEE

Baptist Memorial Hospital, Memphis
Erlanger Hospital, Chattanooga
Memphis General Hospital, Memphis
St. Josephs' Hospital, Memphis
St. Thomas' Hospital, Nashville

TEXAS

Baptist Sanitarium and Hospital, Houston
Baylor Hospital, Dallas
John Sealy Hospital, Galveston.
*Parkland Hospital, Dallas
Providence Hospital, Waco
Robert B. Green Memorial Hospital, San Antonio
St. Joseph's Infirmary, Fort Worth
St. Joseph's Infirmary, Houston
St. Mary's Infirmary, Galveston
St. Paul's Sanitarium, Dallas
Santa Rosa Infirmary, San Antonio
Temple Sanitarium, Temple

UTAH

*Doctor W. H. Groves Latter Day Saints Hospital, Salt Lake City
Holy Cross Hospital, Salt Lake City
St. Mark's Hospital, Salt Lake City

VERMONT

Mary Fletcher Hospital, Burlington

VIRGINIA

Hospital Division of the Medical College of Virginia, Richmond.
Norfolk Protestant Hospital, Norfolk
St. Vincents' Hospital, Norfolk

University of Virginia Hospital, Charlottesville
Virginia Hospital, Richmond

WASHINGTON

Children's Orthopedic Hospital, Seattle
Columbus Sanitarium, Seattle
*Northern Pacific Hospital, Tacoma
Providence Hospital, Seattle
Sacred Heart Hospital, Spokane
St. Elizabeth's Hospital, North Yakima
St. Joseph's Hospital, Tacoma
St. Luke's Hospital, Spokane
Seattle City Hospital, Seattle
Seattle General Hospital, Seattle
Swedish Hospital, Seattle
Tacoma General Hospital, Tacoma

WEST VIRGINIA

*Charleston General Hospital, Charleston
Kessler-Hatfield Hospital, Huntington
Ohio Valley General Hospital, Wheeling
St. Mary's Hospital, Clarksburg
Sheltering Arms Hospital, Hansford
*Wheeling Hospital, Wheeling

WISCONSIN

LaCrosse Lutheran Hospital, LaCrosse
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Milwaukee County Hospital, Milwaukee
*Milwaukee Hospital, Milwaukee
Mount Sinai Hospital, Milwaukee
Sacred Heart Hospital, Eau Claire
St. Agnes' Hospital, Fond du Lac
St. Francis' Hospital, LaCrosse
St. Joseph's Hospital, Marshfield
St. Joseph's Hospital, Milwaukee
St. Mary's Hospital, Green Bay
St. Mary's Hospital, Superior
*Trinity Hospital, Milwaukee

CANADA

ALBERTA

General Hospital, Calgary.
*General Hospital, Edmonton.
General Hospital, Medicine Hat.
Holy Cross Hospital, Calgary.
*Royal Alexandra Hospital, Edmonton.

BRITISH COLUMBIA

Provincial Royal Jubilee Hospital, Victoria
Royal Columbia Hospital, New Westminster
Royal Inland Hospital, Kamloops
St. Joseph's Hospital, Victoria
St. Paul's Hospital, Vancouver
Vancouver General Hospital, Vancouver

MANITOBA

Children's Hospital, Winnipeg
General Hospital, Winnipeg
Misericordia Hospital, Winnipeg
St. Boniface Hospital, St. Boniface

NEW BRUNSWICK

General Hospital, St. John

NOVA SCOTIA

St. Joseph's Hospital, Glace Bay
Victoria General Hospital, Halifax

ONTARIO

*General Hospital, Hamilton
General Hospital, Kingston
Grace Hospital, Toronto
Hospital for Sick Children, Toronto
Hotel Dieu, Kingston
St. Michael's Hospital, Toronto
*Toronto General Hospital, Toronto
Victoria General Hospital, London

QUEBEC

Children's Memorial Hospital, Montreal
Hotel Dieu, Montreal
Jeffrey Hale Hospital, Quebec
Montreal General Hospital, Montreal
Notre Dame Hospital, Montreal
Royal Victoria Hospital, Montreal
*Western Hospital, Montreal

SASKATCHEWAN

City Hospital, Saskatoon
Grey Nun's Hospital, Regina
Regina General Hospital, Regina
St. Paul's Hospital, Saskatoon

TUBERCULOSIS CONFERENCE MEETS

Approximately five hundred delegates were registered for the Mississippi Valley Tuberculosis Conference, one of the largest and most successful in its nine years' history.

Reports from each of the states in the Mississippi Valley indicated a further decline in the tuberculosis death rate for 1921. These reports covered a ten year period and some indicated that when official statistics for 1921 are available, they will be able to show a reduction of 50 per cent in the tuberculosis death rate as compared with the figures of ten years ago. This reduction in tuberculosis mortality rates was attributed in a large measure to the educational work carried on during the past ten years in these states. Dr. Walter McNab Miller, St. Louis, the president of the Conference, ventured the prediction that another decade will see the absolute control of tuberculosis in this country.

With such well known authorities as Dr. Allen K. Krause, Baltimore, Md., editor of the *American Review of Tuberculosis;* Dr. James Alexander Miller, New York, president of the National Tuberculosis Association; and Dr. Haven Emerson, formerly of the United States Veterans' Bureau, on the program, the proceedings of the conference, which will be printed later, will be of great value to those engaged in tuberculosis work throughout the country.

Of outstanding importance was the address of Dr. Krause on the subject: "Solving Tuberculosis—a Many Sided Problem." He urged a larger dissemination of knowledge concerning the disease, commended the work of training children in proper health habits and urged more research work. "If society is to make notable progress against tuberculosis, it must encourage research work," he said.

Dr. Emerson's scathing denunciation of political methods, which he said were being used in the administration of the United States Veterans' Bureau at Washington, attracted nation-wide attention and brought from the director of the Bureau at Washington an immediate reply, in which he announced that Dr. Emerson would be summarily dismissed from the service. His resignation was to have taken effect September 15, two days after this speech.

Speaking on the problem of the tuberculous ex-soldiers, Dr. Emerson endorsed what Dr. David Lyman recently said about the soldiers themselves being one of the greatest handicaps in the movement to provide for their relief, and added this further comment on the attitude of the veterans: "We are facing a series of relationships new in medical experience in this country. We find patients eager to be found sick, grateful for declaration that they are worse, hopeful of continued disability, resenting attempts to persuade them that the will to win is tantamount to recovery, clinging to any straw that will permit them to stay on the hospital roster, indifferent to truth if the monthly check can be increased, reckless in their expenditures for luxuries and gambling and the vices of drugs and liquor, of what is meant to serve them in the period after hospital care when they will be introduced again to the responsibilities of self-support.

"Against this anti-social, unpatriotic, selfish attitude, the whole weight of the medical, nursing and other staffs of hospitals is now directed," said Dr. Emerson, "and it is a struggle between character and intelligence on one side and a still demoralized clientele on the other, which has been so fed and pampered by sentiment that sense has a hard row to hoe."

Dr. Emerson also said that an authoritative report upon standards and rules for discipline and treatment of tuberculosis patients, beneficiaries of the United States Veterans' Bureau, has been prepared by a committee of the National Tuberculosis Association and the American Sanatorium Association, and this, when published and distributed, is certain, he feels, to produce a profound effect upon the men and the character of government institutional care.

The conference adopted a resolution which seeks to clarify the situation relative to general hospitals opening wards for the treatment of tuberculosis. The resolution declares there has been a tendency on the part of the public and public officials in some quarters to interpret resolutions recently adopted by the National Tuberculosis Association, the American Medical Association, and the American Hospital Association, as indicating that such wards may take the place of sanatoriums. Attention is directed to the fact that the real purpose of this policy is that wards in general hospitals are intended in no way to supercede sanatoriums, but to supplement them as clearing houses for diagnosis, for advanced cases, for teaching and emergency purposes.

HOW HOSPITAL RECORDS CAN CONTRIBUTE TO HEALTH PROTECTION*

By HAVEN EMERSON, M.D., New York City

As the individual physician is licensed so will the collective medical services of the hospital be licensed and in an increasing measure operate under certain standards of location, equipment, and administration and be required to give an accounting of its contact with the sick of the community.

Quoting from the report of the Bureau of Hospitals of the State Department of Health of Ohio, January 1, 1921, the following are significant opinions widely held but not yet universally recognized or effectively acted upon throughout the country:

"To appreciate thoroughly the public character of the hospital it must be regarded as a public utility."

"The hospital is essentially a private corporation filling a positive public need. Its sole function is the protection of the public health, and the difference between efficient and inefficient hospital performance is the difference between life and death of human beings."

"Again the functions of these institutions recognized as public utilities are executed by lay individuals while hospital functions are largely administered by a professional personnel, principally physicians and nurses who are licensed or registered as individuals by a public office upon their demonstration to meet prescribed qualifications."

"Morever, hospital functions embrace activities beyond the scope of medical and nursing practice, and independent of all medical service and the most accomplished nursing can give."

"It is those facilities and activities constituting the difference between home and hospital care that differentiate between medical practice and hospital performance."

It will be recalled also that various summaries of hospital services have shown that from 85 to 95 per cent of all hospital beds are in institutions supported by taxation or by voluntary subscription of the public, and are operated, without financial profit, for the benefit of the public.

It may as well be admitted that the sick with certain group exceptions receive more prompt and accurate diagnosis of their conditions and are treated with better success in hospitals than in homes. Furthermore, expressing the opinion of the Council of Health of the American Medical Association we may agree that the future of curative and preventive medical practice depends upon the provision of such hospital, laboratory, and dispensary facilities supported by the public as will permit the application of modern science in a way impracticable through the agency of individual of competitive medical practice.

Hospitals in the future will be licensed as are individual physicians at present, and they will therefore be required to give an account of their contact with the sick.

Aside from the fact that they will be required to give such an account they should do so because in their hands lies the future of preventive medicine. The science of preventive medicine can only advance through the accumulation of facts. These facts mean records. The records will be of three kinds, financial or administrative, social, and medical. On the medical record will diagnosis be based for diagnosis today must be more than a guess.

Records then are demanded in the interest of the hospital's and the physician's conscience, in the interest of the patient's and the community's health, and last and perhaps most far-reaching in the interest of the advancement of science.

Granting then for the sake of argument that hospitals are at present and will be in the future to an even greater extent public utilities serving public needs without thought or object of gain other than in merit and credit in public esteem, are they serving all the functions now possible and expected of them in the preventive aspect of medical practice?

To stop a moment before answering directly, let us recall what is the information contained in hospital records. One section would be financial and what may be called administrative, another social, and the third medical.

Doubtless there are to be found values in health protection in the first two but if so the study of this must come from other sources.

With the medical information I am prepared to deal.

Clinical Record Consists of Facts

Of what does the clinical record of a hospital and dispensary patient consist? There must be social, scientific and administrative facts. There are the patient, the physician, and the hospital to be protected against inadequate service, against loss of data precious to the patient and to society, and against claims that there has been malpractice or neglect. Facts upon which improvements in hospital procedure and management can be based, by which policies and the principles of administration can be tested, require an analysis of the experiences with disease, which the bedside and laboratory services offer Health, human salvage, relief from pain, from disability, from fever and from anxiety, and postponement of death —these are the hospital's output. How success is attained or failure results, because of or in spite of our knowledge or our ignorance; what is myth and mystery, what is superstition and sentiment, to answer such queries, we turn to the record. The record, not our imagination or our memory of past events, but a painstaking entry on imperishable human documents of what is at the same time the glory and cause of humility of medicine, the truth *as* we see it, *when* we see it, the fact as our faltering and unskilled senses take note of it, on the spot, in the presence of suffering humanity, at the autopsy table, while the reaction in test tube or the tissue fragment under the microscope are knocking at our consciousness.

The hospital is the great court before which our social order, our education, our personal habits are exposed in all the tragedy of our failures. How dare we continue our stewardship, we the responsible directors of the human salvage plants, we the servants of the sick offering them

*Read at the Twenty-Third Annual Convention of the American Hospital Association held at West Baden, Ind., Sept. 12-16, 1921.

what we have acquired in the way of science, art, and spirit if we do not as modern apostles write down the record of the lives we are temporarily entrusted with.

Must Have Clinical History for Diagnosis

There is no physician so experienced, or so endowed with intuition that he can make a diagnosis of a *patient*, without a clinical history. A diagnosis of a *disease*, a fracture, malaria, syphilis, diabetes, may be made in the absence of history. But what of the *person* who is sick? Can we afford to know less than all that can be discovered of inheritance, of home, family, background, incidental and ancient difficulties of body and spirit, what has been suffered, what met and overcome? Even the speechless babe has a history, even the patient of foreign tongue needs to tell us what we ought to want to know. A history taken is stolen if not recorded.

The day of clinical impressions is past. We no longer walk in awe at the elbow of the great clinician who makes a diagnosis at arm's length. Diagnosis demands a complete and detailed physical examination of the patient and often a mental study too. Not a study of the lungs only when we expect pneumonia, or of the joints when we talk of rheumatism, but a study of all the body to find out all that is wrong and all that is right and thus save us the humiliation of seeing patients return time and again to the hospital for what should have been corrected at the first admission.

We expect a diagnosis to be more than a guess. It is an opinion of importance and is to be recorded in the interest of honesty. To be proved wrong in a tilt with the incomparable complexities of disease is no disgrace, but to be faced with a record of error is chastening to the spirit and in the right kind of physician whets the intellect.

What Is Treatment?

Is treatment a votive offering to strange gods or is it a rational application of relief following an opinion as to cause, course, and expected outcome of disease? If it is worth giving or doing, it is worth recording so that it won't be done again if it fails, and to give proof of intelligent endeavor if it is successful.

Disease is no more a fixed condition than is health. Health, is human reaction and, until death, is never stationery. Progress to health or into more desperate disease is human history and if only for historical purposes would be worth recording. That a patient enters a hospital with pneumonia and is recorded as dying under operation for empyema leaves too much to the imagination, and among the imaginings will certainly be the suspicion that the listening ear and the testing hand of the examiner lacked industry in the daily search for explanation of persistent fever, and delayed resolution. In any event the progress from pneumonia to empyema is important to science and if recorded may save the next patient's life.

Then when our worst or best is done, when the patient leaves the hospital a living cripple, a healthy convalescent, or when postmortem examination closes the story, shall we be so glad or so sad that we simply note the final date with no estimate of result, no summing up of experience? Shall we dismiss our friend the patient, knowing well that he knows nothing of the cause or means of preventing a repetition of his digestive, his nervous, his occupational disease? Shall we lose the asset of gratitude, the willingness to learn from those who have helped in sickness, and turn the mother loose with no inkling of the laws of health, the necessary precautions which should see her through the early months of the baby's life and her own first maternity convalescence?

In such spirit is the true clinical record taken. With all charity and reasonableness let me report what I have found in a study of 1,000 records of patients recently discharged from twenty of the hospitals of a large municipality.

Six hundred and fourteen had something in the way of a personal history of the patient, and of these not more than 200 could be considered a really adequate clinical history. In other instances a recital of the complaints of the patient or simply a statement of the duration of the present illness were considered adequate for the personal history.

In 528 cases there was some entry of the physical examination of the patient, but of these records not more than 350 showed what would be considered as an adequate examination record upon which the diagnosis might properly be based.

A working diagnosis was given in 684 instances.

Laboratory findings, chiefly routine examination of urine, was recorded in 514 instances.

The treatment as indicated by operative procedure or medication was recorded in 717 cases.

Final or corrected diagnosis, that is, condition on discharge or after operation or confirmed or corrected by pathological findings, was recorded in 560 cases.

Four hundred and thirty-four showed a brief statement of the condition of the patient on discharge, that is, whether improved or unimproved or whether death resulted under care.

Progress notes were found in 381 records and this term has been very generously interpreted; in not more than 150 instances did the record include entry of the observations of the visiting physician or surgeon or of the staff as they examined the patient from day to day during the course of the disease.

In only six of the hospitals whose records were studied could the records of patients be considered adequate either for clinical study by physicians in charge of the patient, by the hospital authorities to determine the character of the work they were responsible for, or by students of clinical medicine who might wish now or later to test the experience of others against new scientific facts and theories.

At only four of the hospitals was there any systematic attempt to make a periodic analysis of clinical experience while the contact with the case was fresh in the minds of the physicians, and in only two of the hospitals of the city, was this clinical conference carried out with sufficient detail and completeness to meet the objects of such a professional undertaking.

It must be understood that records should be filed by disease whatever other files and filing indices may be used. And the index card under disease should show the authorship of the record or in other words the physician or surgeon under whom the patient was cared for. A few hospitals in that city have adopted this principle of filing.

Follow-Up of Record Not Done Carefully

The completion of the record before filing is very loosely provided for in most hospitals. The medical responsibility in the case is followed up in most instances if at all by a clerical representative of the superintendent's office. Elsewhere the follow-up is left to a nurse in charge of the record office. Good practice and sound principle would seem to require that the medical staff themselves should provide such oversight of clinical histories and records as

would insure the records being complete in every detail before leaving the ward for the record room, and as promptly as possible after the discharge or death of the patient. The assignment of an assistant on each service to guarantee the professional completeness of history records is valuable insurance against neglect and carelessness.

Where records are typewritten, as is the case in several hospitals, the appearance of the sheets is vastly improved, and where physical examinations and histories are dictated, there is no economy in having the transcribing done by hand.

Physical examination, histories, progress notes, preoperative, postoperative, final diagnosis, autopsy, condition on discharge, should all be initialed so that the responsibility for the facts recorded or the opinions expressed can be directly traced. It is not thought that there is any real advantage to be gained in the teaching of medicine by the withholding from the student observer, the well considered opinion and diagnosis of physician or surgeon in charge.

Summary Sheet Good for Future Use

Of great convenience for the future use of the histories is what is known and prepared in several hospitals as a summary sheet to be attached to the front of the chart showing the completion of the record with regard to family and personal history, physical examination, diagnosis, progress notes, final diagnosis, postmortem findings, condition on discharge, etc.

In the main, the hospitals apply the same system good or bad for pay, part-pay, and free patients alike, but there are instances where the records of the free patients are far superior to what is entered for the private patients. The presumption that the physician for a private patient has taken a history, made physical examination, and has ascertained the facts usually included in routine laboratory tests may be satisfactory to the hospital, but as a general principle it can be said that irresponsibility and carelessness of method go hand in hand with failure to record observations or to commit one's self to positive findings and opinions. In answer to inquiries which those outside of the hospital circle are bound to ask, namely, are the records sufficient to make possible comparison of hospital method, professional services, and scientific results, we must acknowledge the fact that not more than 25 per cent of the records of patients in these hospitals are taken or kept in such a way as to be of any value whatsoever to the science of medicine or for study of the principles of hospital administration. It is taken for granted that when hospital records are completed and filed they should be accessible to properly accredited workers now and in the future, no matter what their department or the cause for their interest—be it social, medical or administrative.

Endorses Minimum Standard

Briefly I find myself in complete accord in this regard with the minimum standards which have been proposed by the American College of Surgeons—"That accurate and complete case records be written for all patients and filed in an accessible manner in the hospital, a complete case record being one, except in an emergency, which includes: the personal history; the physical examination, with clinical, pathological, and x-ray findings when indicated; the working diagnosis; the treatment, medical and surgical; the medical progress; the condition on discharge with final diagnosis; and, in case of death, the autopsy findings when available." We should add however a further item, namely, that before a patient leaves the hospital, he should be instructed by the physician or under the physician's direction by the social worker or other competent adviser, as to the cause of his illness, what he may expect in the future in the way of recurrence, how he may avoid repetition of his malady or infirmity, and such necessary elements of the laws of hygiene and personal conduct as will make the patient his own best protector of his health in the future.

Furthermore I wish to endorse heartily the recommendations of the American College of Surgeons in regard to the periodic analysis of clinical records as follows: "That the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery, and obstetrics; the clinical records of patients, free and pay, to be the basis for such review and analysis."

Nothing Better than Honest Measurement of Work

Nothing more valuable for the betterment of hospital administration and service can be conceived than an honest measurement of failures and successes as demonstrated by the relentless inquiry of a group of fellow workers within the hospital family.

As a warning to those who would exalt records above results, allow me to suggest that the hospital should avoid the danger of developing records for their own sake. There must be due regard maintained as to the value of the records in relation to the other activities of the hospital. The hospital needs not merely to learn results but also to produce results and then keep itself informed as to what these results are. The hospital that merely finds out what results are, may be said to have a "fish-up" system instead of a follow-up system. Learning what the patient's needs are while the patient is in the hospital or what the possibilities of after-care are in the patient's home environment, then making the patient understand these needs and possibilities, are essential factors in producing results, often just as essential as the after-care itself. In other words there should be an intimate connection between the activities of the social service department and the system of finding out the medical results at certain periods after the patient has been discharged. Unless there is such a connection, the follow-up system becomes mechanical and separated from the positive creative activities of the hospital. The social service department should be expected to furnish to the physician facts regarding the home conditions and other items regarding cases which will assist the physician in making the program for after-care. In the second place, the social service department will aid the patient to understand what this program for after-care is, and thirdly it will help the patient to carry out the program effectively. Accurate and complete medical records are indispensable as a basis of the after-care of the patient.

I know of no better investment for the sake of acquiring public credit, hospital self-respect or for meeting the standards of service than requiring and providing for the taking and keeping of clinical records of patients.

Science advances on the back of accumulated facts.

Up to the present time with rare and individual exceptions the information given out from hospitals has been dry and valueless, and may be called the dead ashes of the great repair shops of humanity.

Hospitals report births, deaths, and in general according to their lights and the local enforcement of the law they report notifiable diseases, (preventable, communicable, and occupational, reasonably completely). Public

health administration has moved too rapidly to be served by such reports, and needs now not only the fact of death but the fact of sickness in all cases. No longer do we wait for the death rate to betray an epidemic. We go into the homes and search for the sick on the first suspicion of presence of various diseases and put them, if possible under hospital conditions of isolation. We do not look to the registrar's record of deaths from lead poisoning or enteritis of infants but we send inspectors and nurses to search for patients while they can still be saved.

Malady in Community Needs Early Diagnosis

In other words just as the curability and preventability of tuberculosis, syphilis, appendicitis, diphtheria, and heart disease depend on early and accurate diagnosis, so the presence of a malady in the community must be early recorded if we would prevent and cure community ills.

Briefly, what would be the greatest single addition to the material upon which modern health protection is based? Abundant, prompt, accurate data on the existence and sources of all diseases.

To require this of the individual practicing physician will be impracticable for a long time to come since neither he nor his patients yet appreciate the necessity of reporting even the serious communicable diseases with any great degree of completeness.

Dr. Dublin Suggests Method

Current morbidity data could be supplied by the hospitals as suggested in the chapter on a system of vital statistics for a municipality by Dr. Dublin. (Part II, Cleveland Hospital and Health Survey, pp. 369-371):

"In no American city of any size is it possible to give the total number of cases admitted to hospitals, both public and private, the diseases for which entrance was sought, the age and sex distribution of the patients, the duration of treatment and the result of the treatment. It is a blemish on the excellent work done by hospitals that this phase of their activities has been left undeveloped almost without exception in the United States. . . .

"The necessity for such records of hospital care is never questioned; but nowhere have the necessary steps been taken to assure the receipt of the facts. In the matter of organization, it would be necessary only to establish a central office, preferably in the bureau of vital statistics of the city, where uniform reports would be received from each of the hospitals of the city for each case on its discharge. Such a standard form would include such basic items as age of the patient, sex, color, nativity, occupation, duration of residence in Cleveland, address, diagnosis on admission and at discharge, a brief summary of the treatment, duration of the treatment, the date of discharge and condition on discharge; a statement of the social service work done or contemplated would make a valuable addition. It would be necessary only for the hospitals of the city to agree upon a simple blank including such items as these, and to send them as completed to the central record office immediately upon the discharge of the patient. A nomenclature and classification of diseases and of conditions or states of the patients on discharge should also be agreed upon. . . .

"In the central office these records would be edited and otherwise prepared for transfer to perforated cards which would then be sorted and tabulated by mechanical devices. At comparatively low cost, it should be possible at the end of each quarter and at the end of the year to have available a series of tables showing for each hospital and for all hospitals combined, the essential facts for the cases discharged during the period."

Method Would Permit of Check

The initial suggestion in this field is to be found in the Reprint No. 5 of the Department of Health of New York City by Dr. Charles F. Bolduan, April, 1913, which gives details of a method which would produce invaluable information to permit of a check and estimate of the relative value of treatments, and a basis upon which an intelligent municipal program could be developed.

Dr. Bolduan however proposed data obtained from a discharge card, while many of the benefits to be expected from hospital reports can come only from a daily record of diagnosis of each case as admitted, with changes of diagnosis as later established.

The discharge card record is perhaps the first step in introducing such a system and the value of this is emphasized also by former Assistant Surgeon General John W. Trask in Public Health Report Supplement No. 12 of April 3, 1914, and by the work of Frederick L. Hoffman in his study of 1913 in the Johns Hopkins Reports.

Other statisticians, including Raymond Pearl, have not only availed themselves of hospital records but have indicated the value in public health work to be expected from further analysis of such data.

Push Inquiry Farther Back

As we have been pushing back the date at which helpful preventive efforts to save maternal and infant life may profitably be employed for the expectant mother, so in an intelligent attack upon sickness we must push our inquiry back towards the date of health and far prior to the death date which is now our index and criterion of results.

Not only hospitals, but dispensaries are in a strategic position which must be used in advancing our knowledge both as to the quantity and quality of sickness, and as stations where the results of preventive measures may be detected.

We talk glibly of health protection, of health leagues, of health departments, and when we analyze their work we find them engaged chiefly in the treatment or alleviation of the end results of disease.

To drop the death rate we split up the reports of deaths into individual causes, and attack our fagot in the old way of the fable by breaking them one at a time, now a big one like infant mortality, now a tiny one like rabies, until the rate has been brought within reasonable distance of a practicable statistical ideal.

Death is often a release not only for the individual but for the community and the dependents. It is sickness, pain, fear, anxiety, that saps human happiness and drops the level of so-called health, which is often merely a label for "being up and about."

Best Source of Information the Hospital

Before we can claim to be developing or even protecting health we must know the sum and character of human sickness. Our first and best and perhaps our last source of information will be the organized medical service shops, the hospitals, and dispensaries, the sanatoriums, convalescent homes and domiciles of the insane, of children, of paupers, and those great institutions now infiltrated throughout the community, the visiting nurse associations, whose experience and records often present a greater range and bulk of material than the larger hospitals of a city or state all combined.

It has been the story of this country that most of the permanent constructive progressive movements in public health have come from private initiative, and later have been assimilated into official policies and administration, and later still have been so approved of as to become incorporated in the sanitary law of the community. It is my suggestion to this association that you authorize a committee on hospital morbidity reports, whose duties shall be at least to enlist the cooperation of some organized hospital group, such for instance as that represented by the Cleveland Hospital Council to the end that uniform

daily reports of admissions, discharges, transfers, deaths, and changes in diagnosis of all hospitalized patients be reported at a central point and there be tabulated and issued at least once a week for the information of the public officers of health and of the practitioners of medicine, and if possible be printed currently in the public press.

It is my belief that in this way necessary knowledge will be promptly available for professional use, and the public will be gradually educated in the true extent, the seasonal occurrence and the occasional formidable proportions of various common diseases.

Confident Would Improve All Medical Work

There would be technical and educational value in the mere mass and currency of the figures, and I am confident that such a system once installed would be found to improve support for all variety of diagnostic, preventive, and curative medical work.

How we have blundered along without it, is hard to see, and once initiated, current hospital morbidity reports will be found as much taken for granted in the scheme of community self-protection as is the weekly report of births and deaths, and of vastly greater ultimate value.

While we now look askance at the states which have failed to meet the minimum civilized requirements of registration laws for human births and deaths it is not unreasonable to expect in the next generation a similar development of public opinion in favor of reports of sickness as it occurs.

Health officers recognize the need, the material is present in abundance, there is lacking only the energy and capacity of a leader among hospital people to take this next step forward. There is no doubt in my mind but that the American Hospital Association will reply as it has always done in the past to each new opportunity for public service. The opportunity awaits you.

WORKING WITHOUT TOOLS

By FRANCES L. GARSIDE, Near East Relief News Service, New York City.

There is no profession that has risen above its handicaps like the medical profession. A carpenter without tools takes a day off, a shoemaker without tools is not a shoemaker, but surgeons without tools are somewhere in the world every day in the year performing marvelous feats of surgery. One has only to look back to the World War to know that.

Of course, these were emergency cases. Sometimes, for days at a stretch, the surgeon had to operate without proper equipment. To do it as a regular thing, however, is more rare, and that is what the physicians and surgeons are doing in the Near East, bringing relief to the patient without the first instrument at hand for doing it. A physician in one of our modern hospitals would throw up his hands in despair if confronted with a patient, and the "kit" used by a practitioner in the Near East.

These men work in hospitals maintained and operated by the generosity of American people through the Near East Relief. Their patients are chiefly among the younger generation; indeed, few mothers and fathers past forty are left. There are younger mothers, girls to whom motherhood is not the joy it proves under happier conditions, and there are many children, suffering from the effects of privation and hardship when driven into exile by the Turks. There are others, whose sufferings are infinitely greater, because the Turks captured them as slaves.

The equipment in these hospitals is not complete, and the little there is is far from modern. There is no electricity, the sterilizers are heated by oil lamps. Newborn babies are cradled in packing boxes, thus, one baby is known as the Coleman's Mustard baby, another as the Royal Baking Powder baby, a third as Crisco, and so forth. The great majority of them are of Armenian mothers, and Turkish or Kurdish fathers. Any day any one of the babies may be claimed by the father, according to Turkish law.

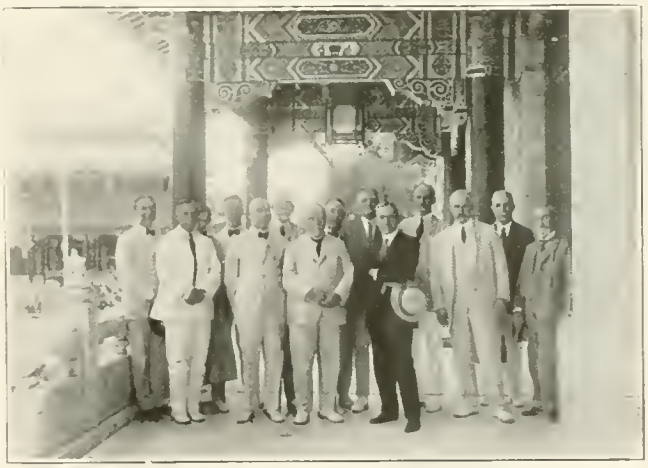
DEDICATE PEKING UNION MEDICAL COLLEGE

The dedication of the Peking Union Medical College, which has been erected and is being maintained by the Rockefeller Foundation in the capital of the Chinese Republic, took place during the week September 15 to September 22, 1921, in connection with an international medical congress and a meeting of the trustees of the college held in Peking. Scientists and delegates from hospitals and medical schools were present from France, England, Scotland, Ireland, Canada, the United States, Japan, Java, the Philippines, and practically every province of China.

Sixteen buildings, including laboratories, hospital wards, out-patient buildings, nurses' home, power plant and auxiliary structures, comprise the institution proper. These buildings, situated on the property of the old palace of Prince Yü, have been erected in Chinese architecture, characteristic of the best of their classic and sacred buildings.

The interiors of the buildings are equipped in the most modern fashion for laboratory, classroom and hospital use. The buildings were started in 1917 and were completed this summer just before the dedication.

The faculty of the school has been assembled from among medical workers who were already in China, from men and women called from other medical institutions in the United States, Canada, and England, and from Chinese trained in Western medicine. This latter group, which already includes a promising number, is expected to increase both in size and in responsibility.



A group of trustees and guests at the dedication of the Union Peking Medical College and Hospital. From left to right they are: Dr. Francis W. Peabody, of Harvard Medical School; Dr. Henry S. Houghton, director of the College; Miss Eggleston, assistant secretary of the board of trustees; Edwin R. Embree, secretary of the Rockefeller Foundation; Prof. Paul Monroe, Teachers College, Columbia University; James L. Barton, secretary American Board of Foreign Missions; Dr. William H. Welch, of Johns Hopkins University; Dr. Richard M. Pearce, director, Foundation's Division of Medical Education; George E. Vincent, president, Rockefeller Foundation; John D. Rockefeller, Jr.; Roger S. Greene, resident director of the Foundation's China Medical Board; F. H. Hawkins, London Missionary Society; Martin A. Ryerson, chairman, board of trustees, University of Chicago; J. Christie Reid, Medical Missionary Association of London.

SOCIAL SERVICE AS RELATED TO OTHER HOSPITAL SERVICES*

By JANET THORNTON, Member of Staff, Committee on Dispensary Development, New York City

There are three fundamental propositions in the present day conception of health:
First: Health is a dynamic rather than static state.
Second: Health is the common interest of all.
Third: The care of health is a cooperative endeavor.
Assenting to these propositions we are led a long way from the old hospital of charitable foundation with its limited care for the few, to a greatly enlarged field of medicine. This field has been enlarged during the last decades in response to the development in the sciences—physical, psychological, and social. And with this development there has not always been a clear differentiation between the services of different types. This is essential for an understanding of the relation of social service to other services, and it is this that Miss Thornton has done with remarkable success.

THAT hospitals and dispensaries exist for the sake of the health of human beings is a commonplace of our faith. Whatever emphasis may fall on particular aspects of their work—such as teaching, research, general and special practice—their great and ultimate purpose is care of the community's health. It is, therefore, the requirements of community health that must determine the essential elements in structure and function of hospital ward or clinic. Fundamental to such conception of health is the thought that health is a dynamic rather than a static process, a condition to be in large measure acquired and achieved (a) by securing things known to be physiological and psychological necessities, e.g., food, oxygen, sleep, movement, warmth, pleasing occupation, companions, obligations; (b) by avoiding things known to be detrimental, e. g., microscopic organisms of various kinds, excesses and errors in foods, overfatigue, prolonged exposure to heat and cold, thwarted desires and balked energies.

The second thought fundamental to present day conception of health is this—that health is the common interest of all. Typhus fever in Poland is our menace as well as the Poles'. Tuberculosis is passed from servant to master. The breakdown of the family of the injured or exploited worker becomes the burden—and shame—of the community. Care of the community's health means care of all the members.

The third thought fundamental to present day conception of health follows as logical sequence from one and two, viz., that the care of health is a cooperative endeavor. It is neither the privilege of the wealthy, nor the beneficent gift of the wealthy to the poor. It is rather the prime interest of all that it become the possession by right of all.

These three propositions, health to be won, health the common interest of all, health the cooperative endeavor, compel our recognition and assent as self-evident and incontrovertible. And once granting them assent, they lead us a long way—we pass beyond the old hospital of charitable foundation with its limited care for the very few and usually the unfortunate—and face out to a great enlargement of the field of medicine. For medicine has been enlarging in recent decades in quick response to developments in the great underlying sciences upon which it grows—physical, psychological, and social. And as the sciences generate more and greater power to serve, more and greater demands are made upon the medical practitioner for public or communal service, while to hospital and dispensary administrators falls the problem of enlarging and adapting plant, equipment and service to suffice for the demands of modern scientific medicine.

It so happens that most of what we have learned of hospitals and dispensaries has been taught us by administrators of large, complex institutions, where differentiation of function is great and easily becomes rigid, often becomes rigid before functional relationships have been well defined. And yet the original elements in structure and function are not very difficult to find or to comprehend, if we approach the subject with open mind. The demands as they relate to plant and equipment have been frequently discussed and well defined. Concerning operating personnel or what we might call service department, classification and functions or activities have not, it seems to me, been so well standardized. Now consideration of this service department and its functions is vital to the subject under discussion—the place of social service in hospital and dispensary administration—because social service, rightly understood and practiced, is an integral and specialized part of the hospital's medical service. It is not a generalized hospital service; neither is it a generalized community service injected from without, nor a graciousness contributed by a ladies' committee.

Has Done a Little of Everything

It happens, too, that hospital social service has originated in old, complex, and much organized institutions—Massachusetts General Hospital, Bellevue, Cook County—and has had to face manifold difficulties of adaptation and has followed many leaders in misleading ways. The most frequent and dangerous pitfall has been the attempt to make up for the many inadequacies of hospital management in other divisions of the service department—housekeeping, clerical, financial, nursing, etc.; meanwhile neglecting its own proper and magnificent service, and worse still, obscuring its vision so that it fails to recognize its own place and tries by mere verbalism to appropriate all manner of heterogeneous activities. Yet withal no one knows better or more painfully than the hospital social worker that the kind and amount of every service, social, clerical, administrative, to supplement the physician, so far recognized as adequate by even the best hospital administrators, is very far from adequate to meet the demands of modern medicine.

How may we reach definition and proper coordination of these hospital activities? Will a study of the activities of clinic and ward yield us facts on which to base definition and proper coordination? I feel sure that such a study is one way to the light, and I propose, therefore, to give a somewhat roughly classified list of activities, and thereupon to endeavor to show how self-evident it is

*Read at the Twenty-Third Annual Convention of the American Hospital Association held at West Baden, Ind., Sept. 12-16, 1921.

that many activities supposed to be social are not social, and conversely, that many not supposed to be social are social.

Hospital Activities (Both Clinic and Ward) Relative to:

I. *Government of Institution.*

Adoption of aims and objects; creation and direction of policies; appointment of operating personnel; responsibility for product and output of work, for publicity or accounting for stewardship, for general financial management.

II. *Upkeep and Operation of Building.*

III. *Selection, Storage, Distribution, Care of Equipment,* viz., furnishings; office and medical appliances and supplies; sterilization and preparation of medical instruments, treatment materials, etc.; care of records, histories, charts, indexes, etc.

IV. *Collection and Disbursement of an Accounting for Funds or Moneys.*

V. *Management of Patients* (in respect to body and person of patients).

1. Preliminary or subsidiary to medical work proper and relative to direction and oversight of patients in clinic or ward.
   a. Registration or securing and recording identifying data.
   b. Classification, social, medical, for assignment to suitable ward or clinic or other medical resources and as to eligibility and proper assessment.
   c. Collection of fees.
   d. Routing.
   e. Maintaining discipline and morale.
2. Relating to medical work proper:
   a. Medical (social) investigation and study of each patient.
      1. Learning what the patient complains of or believes to be the matter.
      2. Observation of patient and his circumstances; from one particular part affected all the way to complete study of organs, systems, functions—with little or much of exact testing (laboratory or other) and little or much of search and insight into personal, social environmental conditions. (Objective symptoms.)
      3. Securing from the patient or others familiar with him (as parent with child) a history of relevant circumstances and events in the patient's life, which may consist of no more than a brief statement of circumstances and events immediately associated with complaint, or may be expanded into an illuminating biography covering heredity, development and environmental conditions.
      4. On ground-work of evidence afforded by the above processes (1, 2, 3) formulation and statement of the medical (social) problem. (Diagnosis.)
   b. Selection and application of remedial measures for medical (social) problem. (Therapy.)
      1. Interference with bodily conditions:
         Surgical,
         Chemical (drugs, etc.),
         Bacteriological (vaccines, serums),
         Mechanical (Massage, manipulation, supports, etc.),
         Electrical,
         Radium, x-ray and other ray therapy,
         Bio-chemical (foods, gland secretions).
      2. Control of Environment:
         Protection so that natural defenses of the body may work at best advantage, e.g., rest in bed,
         Adjustment and change, e.g., working conditions, recreational opportunities, sanitation, etc.
      3. Regulation or change of habits of life and thought, e.g., diet, exercise, apprehensiveness, temper, etc. (Health education of both patient and his community may be included here.)
   c. Recording medical (social) investigation and treatment.
   d. Analyzing, testing, measuring work done in management of patient. (Statistics.)

A similar listing and classifying might be attempted for hospital relationships covering such topics as convalescent care, public health nursing, schools, courts, hazards and hardships of industry, etc., under a heading "Community Relationships" or of cooperation among divisions of the medical work proper, and administrative control of divisions, etc., etc., and the attempt would yield enlightenment and direction. There is not space for it in a paper of this kind, for it still remains to be shown what in the above list of activities is social in the technical sense of hospital social service and what is not. Furthermore it must be shown how broadly social in a non-technical sense (and the distinction between technical and non-technical or non-medical here is most important), almost all hospital matters are, because inextricably related to community needs. Every item under Section I, "Government of Institution," has social bearing in the non-technical sense, but not one in the immediate responsibility of technical hospital social service proper. Hospital social service has the obligation of supplying trustworthy data and interpreting it to those who are responsible for the governing function, and, therefore, it is obligated to keep correct documents and render correct account of its work.

Not Social Because Done by Social Worker

Furthermore, hospital social service is not directly concerned in any way with Section II, "Upkeep and Operation of Building or Plant," nor with Section III, "Selection, Storage, Distribution, Care of Equipment," nor with Section IV, "Collection and Disbursement of and Accounting for Funds." Hospital social workers may reply that they do nevertheless perform sundry functions under each of the four headings. I myself have done so, but styling myself a hospital social worker and then performing certain acts does not necessarily render those acts social in nature. The verbalistic habit of mind which allows us to describe all the professional acts of a person in accordance with an assumed professional character is easily seen to be absurd as soon as expressed; but is there a hospital in the country that is not describing some housekeeping or social function as nursing because performed by a nurse, some business or clerical function social because performed by a social worker? Like many another intellectual fallacy, its absurdity does not reduce its power for evil.

Not until we reach Section V, "Management of Patients," do we find the activities for which hospital social service is immediately responsible and here, too, there is the interweaving of several functions. Taking up the activities one by one, "Registration or the securing and

recording of identifying data" is plainly clerical in nature. Appreciation of social values, however, makes the clerk realize the importance of this activity, enables him to sense and secure the accurate data, and greatly increases his speed and accuracy by virtue of skill in making contacts with people. Yet registration is not a function of hospital social service. "Classification of applicants as to their eligibility for admission, as to proper assessment of fees, and for assignment to suitable ward or clinic," here for the first time the medical function proper comes into play in securing medical data for proper assignment, and also for the first time the medical-social function in correlating the applicant's medical need, the cost of medical treatment for same, his resources and his obligations. "Collection of fees and routing," c and d, may be briefly described as business or administrative and not medical-social. "Maintaining discipline and morale," e, is obviously social in character. It is the kind of social service, however, that is required in schools, factories, etc.,—whenever, indeed, groups of people are managed—and is not, I believe, specifically medical-social.

On the other hand, it is plain from the mere rehearsal that the second group of activities under Section V, those relating to medical work proper, contain much that is medical-social. Will it surprise many physicians to be told that much they do is medical-social service? I believe not, though few perhaps ever stopped doing long enough to think the matter out. Most will grant (1) that eliciting from the patient what he complains of or believes to be the trouble is not just a matter of anatomy or physiology, but is also winning of confidence, understanding a personality, etc., and that these last activities are in essence social; (2) that the actual physical examination of the patient requires a technic that is not in essence social, though even here a sympathy with the patient's temperament or rhythm seems to make a strange difference. "The search and insight into personal, social and environmental conditions" is strictly social. (3) Lastly, "Securing from the patient or others familiar with him a history of relevant circumstances or events in the patient's life," is unquestionably a major part in social functioning. It may be concluded, then, that in reaching almost any complete medical diagnosis, social aspects have been considered as causative factors, and some social functioning has revealed the patient.

Passing on to medical treatment, the importance of understanding and managing the personal, social, economic situation of the patient becomes still greater. It is of minor importance in the actual "interference with bodily condition" (Process 1). It is undeniably of major importance in "Control of environment" (Process 2), and "Regulation or change of habits of life and thought" (Process 3). Many illustrations can be brought forward to show that in medical practice of the most tested and standard kind, regulation and re-education of the patient, accompanied by removal of strains from without, constitute almost the whole of treatment; and here again the mere rehearsal of the processes of treatment suggests the importance of social service.

Medicine to Considerable Extent Social

May it, therefore, not be finally concluded that a very considerable part of the practice of medicine has to do with the personal and social life of the patient, much of it with the intimate, often humdrum affairs of every day, and that it is, therefore, right and proper to say that the practice of medicine is to a considerable extent social service?

The thought that medicine should concern itself with these things is not new; the intention to systematize and organize hospital procedures, so that full consideration shall be given to all social factors relevant to the medical problems of patients, is new or at least so new that a practical procedure for serving all patients rather than a few is only just being worked out. The procedure requires that cognizance be taken of the personal and social as well as the strictly medical conditions and needs of all patients from the moment of application to the hospital, and that the patients shall feel that their individual needs will receive the special care which may be necessary. Social as well as medical record is kept of each case, so that the physician has complete data at hand when summing up for diagnosis and treatment. It is the task of the specialist in social work, collaborating with the physician, to correlate the medical plan with the circumstances of the patient's life and make necessary adjustments.

Make the Patient Help

The general policy pursued is to make the patient a partner in the conduct of his medical care, up to the limit of his understanding, appealing to his intelligence and giving him something to do, and having him do all he can for himself. To follow this procedure it is necessary for the doctor or social worker to tell the patient a good deal about his malady, and to outline at least roughly the plan of treatment, especially as to probable duration and immediate steps to be taken. Furthermore it is desirable and all but necessary to review in detail the relationship of the plan of treatment and the patient's particular plan of life. The mere fact of assisting into clear consciousness all factors of a patient's case, be they helps or hindrances, contributes much toward the solution of his problem. It has been demonstrated that this process of analysis alone gives a fairly high percentage of achievement among people of good intelligence and character, where, without it, among the same people, the percentage is low. Careful talking out, point by point, of each item of the plan, is a great help in getting the patient to understand and see his way clear to carry out the plan. For instance, the medical plan may require the patient to return for treatment too or three times a week over a period of several weeks, or it may require the patient to carry out at home at regular times, certain procedures, such as irrigation, special feeding, rest periods. To adapt or change the day's routine to these therapeutic measures may well call for thoughtful management and sustained effort.

The social worker makes concise entries on a social card of the doctor's recommendations and arrangement for appointments. This card is filed in calendar index under the date of the next appointment and from day to day as the case proceeds. If the patient fails to keep his appointment a letter is sent him, or in more serious cases a visit is paid to remind him and to recall very briefly the plan and instructions talked over with him. The distinction between the interpretative manner of procedure here attempted and a purely mechanical "follow-up" not founded on mutual understanding between patient and hospital is of the utmost importance. Much misunderstanding of the true place and need of the social function in medical work has arisen from describing the mere clerical communication with patients regarding appointments as social work. And whereas the adoption of mechanical devices for follow-up seemed a first step toward social work in some instances, the continued supervision in a mechanical manner only, now appears to me almost more detrimental than absence of supervision, since by missing

the main point of social service in hospital work, the very heart of it—interpretation—it deceives those who practice it and those who support it and thus retards the ultimate socialization of the clinic.

Social Worker Must Overcome Certain Obstacles

Where obstacles for treatment arise greater than the patient can handle unaided, the social worker must decide what resource in the community can give the needed assistance. For example, a district nurse will be asked to watch the temperature and pulse, or give an enema; a vehicle will be secured to bring the sick, old, crippled, or a mother with several small children, etc., back to the hospital; while a few cases will be discovered to need intensive investigation outside the clinic or ward, and organization of extensive relief and corrective measures.

Analysis and classification of the staff or personnel to execute all the activities and procedures above studied can be made to look very simple on paper. In fact, it seems not possible to make more than three big divisions, viz.:

(1) Medical staff,

(2) Assistants or aides to the medical staff,

(3) Administrative staff, together with a governing body, and chief executive or superintendent. Hospital social workers, together with technicians and clerical workers, take their place in Division 2 as assistants to the medical staff. Unless the functions of the three personnel groups are rightly defined, confusion must result. Having defined the functions and learned the technic for their performance, there is no intrinsic reason why one person may not perform many functions. In small institutions, neighborhood clinics for instance, it is often necessary that the executive should fulfill the duties of administration, clerical, nursing, social service and others. Similarly, physicians are many times called on to play the rôle of friend, business adviser, social worker, nurse, etc., as well as practitioner of several medical specialties.

Must Not Neglect Own Responsibility

It may often happen that the social worker in the hospital may be called upon to do things that are not technically hospital social service. Social workers given administrative charge of clinics, for instance, must perform or supervise much clerical work, often business details and even housekeeping matters. The combination of responsibilities is reasonable and it is for the social worker to see to it that she has assistants enough so that the most important responsibility assigned her, viz.: the social service, shall not be neglected. For the social worker must ever bear in mind that the personality of the patient must be reckoned with in nearly all medical processes except those within the laboratory; that the study of character and behavior, the efforts to change habits of thought and behavior, to control environment or in general the social aspects of medicine, are today not usually performed in the systematic, scientific manner of the other more standardized processes of medical work.

Yet a survey of the activities of medical service shows the presence and importance of these elements. If patients are to win health, if the health interests of the community are to be advanced and safeguarded, the social aspects of medicine must be more deeply studied and more skillfully practiced.

Dr. J. N. Hurty, secretary of the state board of health in Indiana, stated at a mass meeting in Lafayette that America is fifteen years behind Japan in public health work. He is in favor of employing an all-time public health officer in cities, and procuring sufficient funds from the legislature to carry on the work on a proper scale.

NEW YORK AS A MEDICAL CENTER

By ALEXANDER H. CANDLISH, Superintendent, New York Post Graduate Medical School and Hospital, New York City.

The reason that the question of medical centers now claims the attention of the medical profession of this country is clearly apparent.

Medical men in America who have been keenly alert to existing conditions in the medical centers of Europe, have long since noted a great decline in their popularity with American students. This decline was observable long before the ravages of warfare had made European cities uninviting to Americans. In fact, it can be definitely stated that the gradual decline of foreign institutions of learning was inevitable, and that the war but hastened the total cessation of their activities.

In former years men of unsurpassed medical ability in this country were ignored by students in the belief that better knowledge in technique in surgery or in physical diagnosis or in one or more of the specialties could be more readily gained in a foreign medical school than from men of ability in equally good institutions at home.

However, it is quite germane to this subject to state that in former years anything foreign was considered superior to what could be obtained at home, this fact being made to refer to the gaining of medical knowledge in particular.

Language and Customs Bar to Education

The average American does not acquire knowledge of foreign languages readily, consequently graduates of medicine on going to Europe were in the majority of cases quite unfamiliar with the language and with the textbooks of the country. Even the manners and the customs of the people with whom they lived added in no small measure to misunderstanding. But the principal difference was the mode and treatment of patients there as compared with the treatment of patients in this country. There the patients were "cases" only, thus adding to the difficulty of obtaining knowledge from these patients. There was also the assumed superiority of the professors not only to the patient but to the student also, thus preventing in many instances an exchange of ideas between professor and student regarding the patients, demonstrated in the class or clinic.

Graduates of medicine and undergraduates went to foreign schools of learning influenced to some extent by the thought that a physician who had studied abroad was considered by his friends, and especially by his patients, to be more eminent and doubtless possessed of much more ability than the surgeon or physician who had received tuition in America. There was also the attraction to foreign clinics created by interesting cases being presented there. This condition is now met at home, and as New York is the gateway to this country, there is a continuous flow of foreigners entering the port, who are suffering from rare diseases, which necessitate their being treated in the hospitals of this city, prior to their being admitted to the country to live or being deported.

Students Will Come to America

The time has passed when comparisons of professors and teachers abroad with professors and teachers at home can be considered, for in keeping with the magnificent growth of this country, our men of science, and especially those of the medical profession, have kept pace, and today there are men in the profession in this country whose reputation in every specialty of medicine and surgery is more than national. This condition recognized, students will remain here and foreign students will come

to America for medical education and for postgraduate instruction especially.

Since the war this country has benefited by the great number of students who have come here from Mexico, South America, and from our various possessions for postgraduate medical education. These men have carried to their homes clearer ideas of American life. The eminence of our teachers, the superabundance of clinical material and the ever-increasing number of large, well equipped hospitals, when made known to others contemplating medical studies, can bring but one result.

In one teaching institution in New York City alone there is a daily attendance of from eight hundred to one thousand outdoor patients, this but attests that no other city at home or abroad has such a wealth of material. When it is also considered that in the one hundred or more hospitals located in Greater New York there are over 28,080 beds, this but makes the attraction to this city the greater.

In addition to interesting material being available, the wealth of the country, New York in particular, has limitless possibilities for the erection of institutions of learning. Students will therefore realize that here and not in Europe are the greatest facilities offered in medical education.

Centralization is the thought of the times, evidenced in the centering of large business concerns. The centralization of medical teaching is necessary, and is being suggested by the majority of broad-minded men in the profession. Centralization has been recommended by every survey of medical colleges. Where limited facilities obtain, either in equipment or in clinical material, this is not only unprofitable but unsatisfactory, and as to the question of smaller places being thought of as medical centers, this, for obvious reasons, cannot be considered.

Consolidation has already taken place between a great New York university and a well known hospital. If the affiliation of other institutions continues, the time is not far distant when New York City will offer the most complete facilities for medical instructions to be found either at home or abroad.

HOSPITAL ACCOUNTING AS A BASIS FOR HOSPITAL ANALYSIS*

By FRANK E. CHAPMAN, Director, Mount Sinai Hospital, Cleveland, Ohio

ONE of the idiosyncrasies of hospital administration is the reaction that is obtained by talking to groups of administrators about their accounting problem. One gains the impression that the recording of hospital performance is looked upon with a great deal of tolerance, in fact, with indifference, and that the problem of properly recording activities is an obnoxious one. The general impression seems to be that the recording of this performance and the analysis of such records is a dry, unpleasant task. One cannot help but believe that this point of view is prevalent because of a lack of understanding of what properly recorded facts mean, and a realization of what intelligent analysis of records will bring to an administrator.

Intelligently recorded figures are far from dry. They furnish a problem of study that is indeed interesting. The sole object of this discussion is an attempt to bring to all of us a better realization of the advantages of proper accounting, and to present the problem so that it may seem less foreboding.

There is only one excuse for the existence of any accounting system. That excuse is that it serves as a basis for analysis. A large percentage of the overhead of commercial activities is expended in proper cost and production accounting. If, in the wisdom of those who have made a success in business, these expenses are indicated, is it not logical to assume that in handling the most precious of all commodities, human life, the same relative degree of expense is warranted in analyzing the performance of a hospital? The various types of accounting that it will be attempted to outline have a very close similarity to the various types of accounting in business.

How often have we been confronted with a request as to certain activities of the institution, and been compelled to answer that while the information is obtainable it will have to be computed? Statistics of any type are of no value unless they are readily available. Statistics of the financial performance of the institution, to be of value, must be made available within at least fifteen days after the current month has passed or their potentiality for good is lost.

Medical Histories

There is, of course, the ever-present problem of medical histories. There has been a great deal of criticism of the standardization program of the American College of Surgeons. Some say that there has been an attempt made to stimulate paper medicine to the exclusion of the clinical practice, but it is submitted that such an attitude shows an exceedingly narrow point of view as to end results to be obtained, by the proper recording of the medical performance. After all, the medical history and the analysis obtainable therefrom is the production chart of the hospital, and no more careful check should be instituted in the institution than an analysis of our medical performance. It is not contemplated that this article deal with any details of records. This is a problem that must be worked out by each institution. An attempt will be made merely to outline the pertinent requirements, with the hope that with these fundamentals established, institutions may work out their individual requirements as the demand may indicate.

No record is complete unless there is an analysis of results and this analysis made available for commendation or criticism as the performance may merit. It was my privilege to work out and put in actual operation the analysis sheet that is now advocated by the American College of Surgeons, and I wish to emphasize most strongly that the results obtained by the use of this sheet have justified all the time and effort necessary in putting it into effect. I could recite several instances any one of which justified the time and money spent upon it.

The completeness of a history is dependent upon the physical examination, the personal history, statement of present illness, admission diagnosis, operating notes, completely recorded, progress notes, recorded consultations,

*Read at the Second Annual Convention of the Wisconsin Hospital Association, held at Milwaukee, Wis., May 25-26, 1921.

statement of laboratory work, statement of x-ray work, final diagnosis, and condition on discharge. If these things are included in the history, the details of obtaining them and the manner of recording are incidental.

Daily Statement of Vital Performance

All institutions, no matter how small, should maintain a day book of vital performance. This day book may be as large or as small as the institution may desire. The only requisite is that it have at least thirty-two lines, one for each day of the month, and a line for the total. As a concrete illustration, this book may have as headings: Admissions, births, deaths (institutional), deaths (within forty-eight hours), discharges, pay patients, part-pay patients, free patients, total number of patients, number of patients on each ward, number of operations, number of anesthetics, number of x-ray treatments, etc., classification of medical distribution, and in fact any information that is required for current use.

After this book is once set up, it will be necessary to see to it that a statement of the previous day's performance is entered on the proper line today. At any time during the month, it merely means footing a column to furnish the activity for that period. At the end of the month, it merely means adding all of the columns, balancing them out, and transferring them to a page at the back of the book for the year, to give the performance for the month, and to give a one-twelfth basis for the year's performance. At the end of the year, it merely means adding twelve figures in each column to give the hospital's performance for the entire year. Such a book can be maintained in not to exceed thirty minutes work per day in the largest institution in the country, and certainly the results are more than justified.

Financial Records

One of the saddest commentaries in hospital operation today is the attitude of boards of trustees towards their financial records. Most of our boards of trustees are selected because of preeminent success in their personal activities, but when they are elected to membership on a board of trustees, they seemingly forget all of the things that have made them successful in their personal activities, and permit a practice in their hospital that cannot possibly produce the most efficient results. It is hard to understand how an intelligent analysis can be made of a hospital's performance, financially, with the method of bookkeeping that is in vogue in most of our institutions.

A very prevalent practice is that of lumping all salaries spent, under one heading of pay-roll. It would seem that the item of pay-roll means very little in any hospital. The information that is desired is how much of that pay-roll went to administration, how much to housekeeping, how much to dietary, *ad infinitum*. It is recommended that one of the first principles of properly recording hospital finances is to set up a chart of accounts that will reflect the individual departmental performance of the various units of the hospital, so that comparable periods may be analyzed one against the other, to note the performance for those periods. This chart of accounts may be elaborate or simple, dependent entirely upon the demands of the administration, but it is to be hoped that it will not be so simple as to eliminate a basis for computing the cost of various departments. With such a chart of accounts established, then it is incumbent that payments of all types be distributed accordingly.

The same criticism that is made of the method of bookkeeping is made of the financial policy of most institutions. There seems to be the thought that someone will provide, and that we are going to attempt to collect as much money as we can and spend as little money as we can, and hope that we are going to have enough money to pay our bills at the end of each month. I don't believe that anything can be accomplished unless there is a goal set for that accomplishment, and the only way that I know to create a goal for the financial performance is an absolute adherence to a budget system of accounting.

Income Accounts

We know by our records, or should know, how many patient days' care we should furnish for a given year. We know, or should know, the percentage of these days that are full-pay, part-pay, and free. It will be very easy, at least, I find it so, to compute for each year the approximate earnings for the institution for the year to come. As a specific illustration, if I have twenty rooms that rent for $5.00 a day, it is reasonable to assume that I will earn twenty rooms times 365 days times 80 per cent occupancy times $5.00. It is reasonable to assume that I will earn twenty rooms times two operations times 40 per cent operative cases times operating room fee. I can compute any special charges in a like manner. All of this added up will give your earning power for the hospital for the year. This divided by one-twelfth gives the average earning for the month, and may I say to you that the injection of a little spirit of competition into your office force, making them realize that their performance will be judged in part according to their ability to exceed their budget goal of collection, is productive of great good.

Expense Accounts

I am thoroughly a believer in departmental division of expense. I believe that if the dietitian of the hospital knows that she is responsible for the financial performance of her department, that she is going to work harder to live within that budget, and to reduce the number of complaints that she has, than if she feels that she may ask for this and that and the other thing without any set program of performance.

The item of salary is an exceedingly easy one to compute. We merely take the number of our personnel and multiply by their rate for the year and the total of such compilation is the total salary budget. After this budget figure is once set up the department head must realize that he or she must live within that budget.

On the item of supplies, it is comparatively easy if your chart of accounts is properly sub-divided to figure out in actual pounds of commodity or actual yards of commodity, multiplied by an average market price, the amount of money that will be necessary for these supplies. This added together plus a certain percentage for emergencies, divided by twelve gives the average monthly expenditure for each department in the institution.

Confide in Department Heads

There should be no attempt made to conceal true figures from your department heads. Take them into your confidence. Tell them the amount of money that they have to spend. Show them what they are doing each month, and if the spirit of the administration is right, and the intelligence of the department head is proper, you will get a much better result than you could possibly get by a hit and miss financial policy. It is the policy of this institution, that each department head is personally responsible for his financial performance; that the percentage of saving that he effects under his budget, in conjunction with a consideration of the manner in which his department is conducted, is the basis of judgment of his performance, and under normal times there is no reason why every department in the institution cannot live within its budget

provided that budget is properly computed. With such a budget worked out, and with careful watching of the recorded performance, the trail is carefully charted for a successful and efficiently conducted voyage.

I cannot help but reiterate the importance of analysis. If the administrator sets up the machinery of his institution so that these figures will come to him in proper form, and he will really study them with the idea of attempting to discover the weakness of the various performances, he will find them of much more interest than he has thought possible. I must emphasize that this analysis must be made current. Last month's analysis cannot be made three months in the future and be of any value. If it is made quickly and used intelligently the end results will be ample compensation.

The handling of hospital funds and the operation of a hospital is a sacred trust, and entails a degree of obligation far in excess of the handling of most funds. Communities contribute of their money to hospitals because they have faith in the efficiency of these hospitals, and because they believe that they are assisting in a wonderful work. I believe it is incumbent upon the administrators of hospitals to so conduct their affairs that the trust is not misplaced, and I do not believe that this can be accomplished without an intelligent recording of all activities of the institution.

NURSES' MEMORIAL AT BORDEAUX

AS A memorial to their sister nurses who died in service, the American nurses have erected a building at Bordeaux, France, which will house the Florence Nightingale School of Nursing.

The following cablegram was recently received at National Headquarters of the American Red Cross in Washington, D. C.:

"Bordeaux. Most interesting and remarkable ceremony. Please transmit our grateful recognition to the three organizations. Be assured we shall maintain your standards.—Dr. Hamilton, President Cruse."

The dedication of this building not only serves as a memorial to the brave American women who gave their lives for humanity, but marks an important epoch in the development of nursing in France. So quietly did the nurses go about collecting the money for the building that comparatively few people knew that more than $50,000 was subscribed for this purpose, most of it by the nurses themselves, through the three large nursing associations—the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing. A few laymen and women who were on the committee on disbursements and transfer of funds, contributed a small part of this amount.

Photographed by the American Red Cross.

A view of one of the wards in the Florence Nightingale Hospital in Bordeaux.

The plans for the school were submitted to the national nurses' organization as well as to the committee on disbursements. They incorporate, in addition to an up-to-date dormitory, the necessary classrooms for the conduct of a modern school of nursing. The perpetuation of the school upon acceptable standards has been indicated by the terms of the gift, and the further assurance from the board of trustees, as witnessed by the cablegram signed by Dr. Anna Hamilton, superintendent of the hospital, and Dr. Cruse, president of the hospital in Bordeaux, will greatly interest all the nurses in this country.

This school of nursing which now numbers twenty-six pupils was organized eighteen years ago. Mlle. Anna Hamilton, a doctor of medicine, has been superintendent of the hospital and "directrice" of nurses with the assistance of Mlle. Mignot, a graduate nurse, "sous directrice," since the school was established. As soon as she began her professional career, Dr. Hamilton realized that a physician was seriously handicapped without scientific nursing service. Therefore, she concluded to devote her time to the training of nurses. The result of Dr. Hamilton's efforts is the Florence Nightingale School of Nursing in connection with the hospital, a school which compares favorably with the standard schools of America. The students are young women of education, some of them college graduates, of the best families, and are called upon to meet the most rigid requirements of the standard training schools of any country. They receive education and training in medical and surgical nursing, nursing care of infants and children, and obstetrical nursing. The teaching is thorough and as advanced in practical experience as is possible in a hospital of sixty beds. They learn practical housekeeping, including cooking, elements of pharmacy, and details of the administration of small institutions.

The department of visiting nursing is conducted in a modern, systematic, advanced way, and occupies a most delightful and well planned building, erected by the American Red Cross.

The serious handicap in furthering the advancement of the school has been the lack of a home for the students with the necessary demonstration room for preliminary instruction and the laboratory facilities for practical teaching of the sciences, as well as suitable living quarters to satisfy the needs of the type of student sought. The

Photographed by the American Red Cross.
Children's ward in the Florence Nightingale Hospital.

Rockefeller Institute has given ten scholarships for pupils to receive general nursing education in the Florence Nightingale School, with part of the last year devoted to public health nursing instruction. These pupils have already been selected, and are awaiting admission, but have been delayed because of the lack of room in the school.

Mlle. E. Bosc, an old resident of Bordeaux, learning of the high standard of the school and the work of the hospital, gave to the institution before her death, her estate, "Bagatelle,"—an estate of sixteen acres, just outside of the city limits to be used as a building site, and the grounds for a hospital and a school for nurses. It is believed that Bordeaux can support a 200-bed hospital.

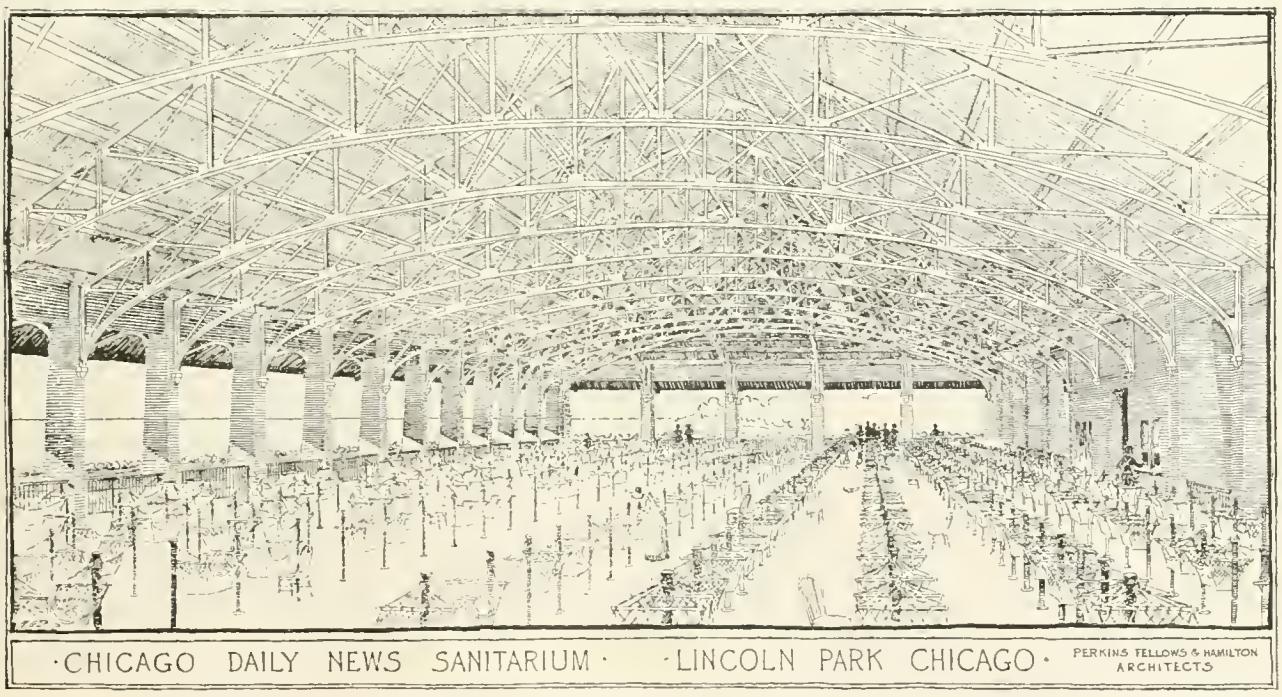
The history of this hospital at Bordeaux is very interesting. It has been operated about fifty-seven years and was built with the particular purpose of caring for all foreign officers and seafaring men, and at the same time meeting the hospital needs of the residents of Bordeaux. There was a great prejudice against such institutions at that time, so in planning the hospital the idea was to erect a building that would suggest a hospital as little as possible. Practically no consideration was given to hospital facilities and conveniences, so the memorial building will fill a long felt need. Over the entrances of the new building, front and back, will be the inscription, "American Nurses' Memorial," while in the large central hall a bronze tablet will be hung giving a detailed description of the gift. Another tablet of bronze, as a memorial to Amabel Scharf Roberts, contributed by the Alumnae Association of the Presbyterian Hospital Training School for Nurses, New York City, will be placed in the library.

SUNSHINE AND LAKE BREEZES AT THE CHICAGO DAILY NEWS SANITARIUM

"MAYBE we've died and dis is Heaven," said bewildered Rosie to no less bewildered little Herman, as they clung to one another's hands and waited for something else astonishing to happen. Then the white figure whom Rosie had quickly classified as "a anjul," said, "No, this isn't Heaven." Then, in an aside, "We bring you here to keep you from going to Heaven so soon." Rosie was more puzzled than ever. Heaven had always been pictured as a wonderful place with gold streets and lots of ice cream, and the paradox of painting it as the most wonderful place imaginable and then doing all in one's power to keep away from it had never before crossed her mind.

But this was near enough to Heaven. The angel continued, "We bring you here to play all day out there in the sunshine, and at noon you may have all the milk and bread and butter you can eat. Now run along."

They were too numb with wonder and a slow-dawning



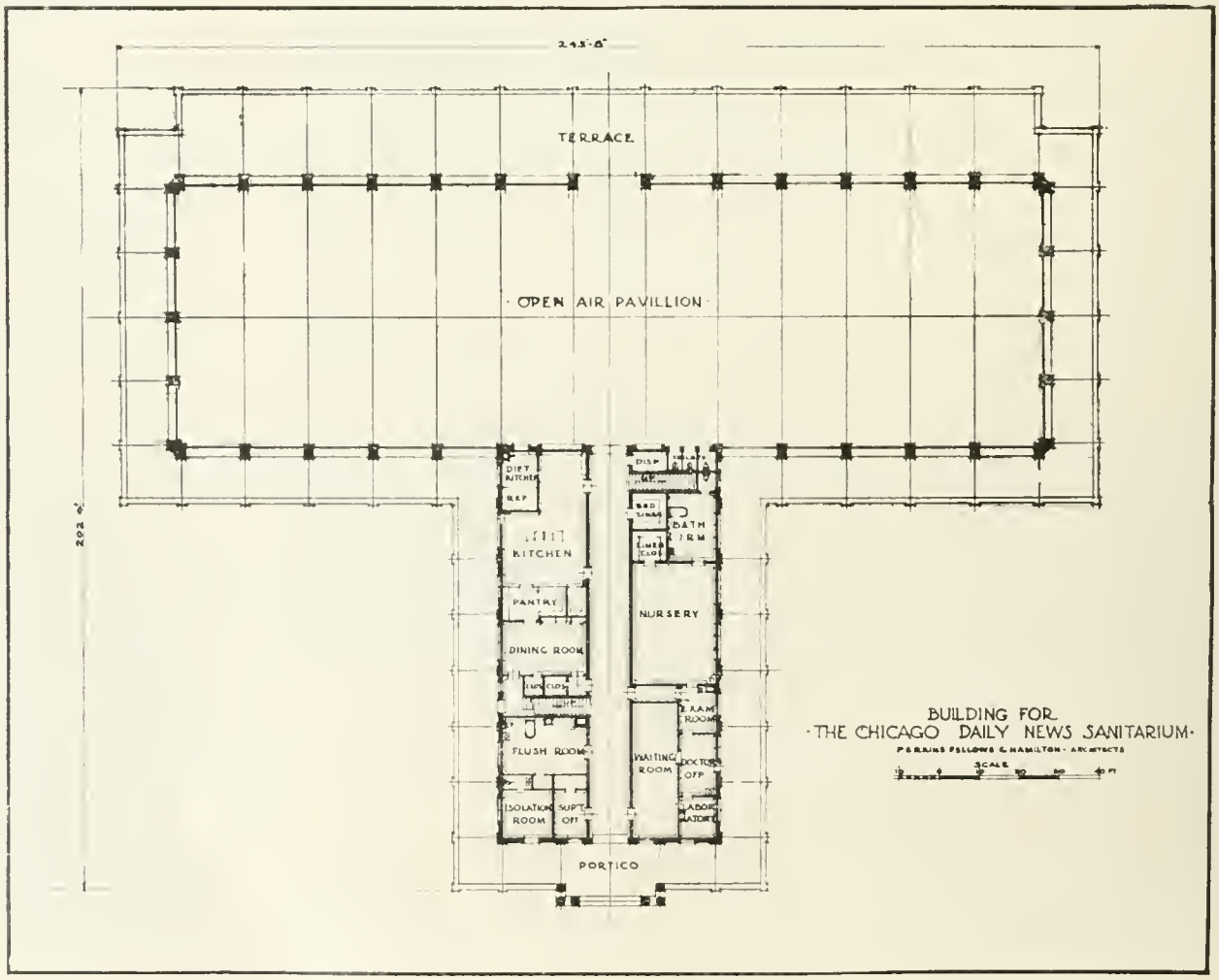
joy to run—but they walked slowly, cautiously, out of the airy building where their mother and the sick baby were sitting talking to a man-angel all in white—out on real grass and on to the very edge of the blue lake. The water was dancing invitingly.

"That's the ocean," said Herman, knowingly. "And over there is China," broke in Rosie, not to be outdone. "No it isn't, it's New York." Just then an aeroplane came into view, flying low over the water. The sunlight flashed on its wings turning them to silver. "That's God in there," whispered Rosie, unable to relinquish her ideas of the celestial sphere.

But, while the older children are turned loose on this enchanted island of breezes and sunshine, their mother, Mrs. Pinsuti, and the baby that "cries all day, he do," are sitting in the long airy hall of the Daily News Sanitarium, on Picnic Island, Chicago, before a white suited intern. Here the ailments are told to sympathetic ears, then as this is the baby's first visit, Mrs. Pinsuti is ushered into the record room where a card is made out, bearing a few instructions for treatment and diet. This is a "season ticket" and is kept by the mother and presented on each visit. Here also the history sheet is filled out. Next the baby is taken to the examination room which is a part of the very complete hospital within a pavilion, or better, the hospital to which a pavilion has been added. This room and the doctor's office are fitted with the best of medicines, thermometers, stethoscopes, and everything that is needed for efficient treatment. The laboratory, though small, is startlingly white and fitted to make most of the tests which are necessary, although this will have equipment added to it from time to time. The nursery where very sick babies are kept has about thirty little hospital beds, weighing scales, ice caps, and other necessary accessories. When a case is very serious the sanitarium doctors have not the heart to send it home at night and arrangements are made to keep the child and the mother over night—or for several nights if necessary. The superintendent, Dr. R. P. Barstow, hopes to develop this feature until it will be quite possible to keep a good many children over night.

Across the hall from the nursery is another well equipped examination room which can also be used for an emergency room if, as sometimes happens, accident cases from nearby are brought in; a diet kitchen, furnished with refrigerators, filters, milk testers, etc.; and a dining room where the staff, consisting of four interns, eight nurses, and the superintendent, have their noonday meal. There is also a large visiting staff of physicians. Every room is pleasant, clean, and has from its windows a glorious view of sky, lake, and across the little waterway, Lake Shore Drive and Lincoln Park. In the distance, to the south loom the tall buildings of the city.

On the lake side of the building is the pavilion which is a huge porch with graceful arches, which suggest the name given to it by Dr. Barstow, her "cathedral." This is filled with little wire high-sided baskets hung from the ceiling and supplied with comfortable mattresses. Here the



A floor plan of the Chicago Daily News Sanitarium.

babies spend most of the day. There is a drug department opening on to the porch where prescriptions are filled free of charge. On the other side the diet orders which are written out on the baby's card are filled according to the specified interval, mixture, and amount.

Upstairs is a wonderful laundry—not the dingy basement which those women have known by that name, but a cool, light room with stationary tubs, hot and cold water, soap and electric irons—all free. Here many of the mothers do their laundry work while their babies are asleep on the porch. If the children arrive in dirty clothes a few simple clean things are provided, and it is suggested that the mother wash the clothes out in the laundry. This she is usually only too glad to do. First, however, a bath is given to the baby, with instructions to the mother as to how and how often to do it again.

The pavilion is a busy place on hot days.

Upstairs also are dressing rooms for the staff, a dormitory for the four nurses who live there, a spacious store room, and a large room of infinite possibilities but whose destiny has not yet been decided upon. It may be used to accommodate the mothers who wish to stay over night with sick children, or possibly for physical therapeutics which is now carried on downstairs in one of the examining rooms.

The basement has a very good furnace which could heat the building adequately even in winter weather, a garbage consumer, and a refrigerating plant which makes the ice for the whole institution.

Dr. Barstow hopes for many things—a full time recreational expert on the terrace, an all year-round service, and expansion, along several lines of the wonderful work which this institution is doing. As one looks around, the spontaneous exclamation is "What infinite possibilities!"

During the hot weather of the 1921 season over a thousand people came to the sanitarium a day, about 150 being babies, the rest mothers and children. During the cooler weather the daily average of babies was about forty. Thousands of people whisked away from heat and pavements, and heavy atmosphere, to—this!

But it is time now for Mrs. Pinsuti to round up the reluctant Rosie and Herman and, baby under her arm, to start for the bus. This, the bus which brought them this morning, will take them through the Park and deposit them at a place where they can get the west side car line which will take them directly to their home.

Herman is too happy and sleepy to talk but Rosie is full of the day's happenings, "Ma, we went wadin', and Ma that nice lady talked to us and we"—They are being bundled into the bus but above the clatter of the wheels sounds Rosie's voice triumphantly, "We kin go back tomorrow, kin we Ma? The lady said we could, Ma."

There is a very complete hospital with thirty beds.

INVESTIGATES CONVALESCENT NEEDS

Miss Mollie E. Sinclair, supervisor of the admission department of the Burke Foundation, White Plains, New York, made a study through the Sturgis Research Fund of the convalescent provision and needs of New York City. The purposes of the study were to determine the most pressing convalescent needs, and how to aid in filling them, either by the addition of new homes or through readjustments and better coordinations in the existing organization. The findings of this investigation are embodied in a little pamphlet reprinted from *Hospital Social Service*, 1921, Vol. 377, which gives some interesting and valable information.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
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Western Reserve University, Cleveland, Ohio

POPULAR FALLACIES ABOUT NURSING EDUCATION*

BY ISABEL M. STEWART, R.N., TEACHERS COLLEGE, COLUMBIA UNIVERSITY, NEW YORK

SOME of you have undoubtedly read a recent novel called "Potterism," which is a rather clever satire on our muddled ways of thinking. I'm afraid the great majority of us are inclined to be "Potters"—loose thinkers, refusing to get down to the bottom of things, accepting the conventional view, always tending to twist the truth a little to satisfy our own selfish desires and sentimental fancies, and even where we hold to the truth ourselves, not always courageous enough to defend it before others.

REBUILD EDUCATION ON NEW LINES

"This is a critical period in nursing education and we must see clearly and build wisely if our work is to stand for the future. The first essential is that we should clear the ground of the old, outworn or unsound timbers which are giving way under the strain of modern demands and the spirit of a new age. Then we shall be better prepared to rebuild our structure, using the best materials and a sounder foundation, fashioning the whole plan on broader lines to accommodate the widely varied activities of our modern profession of nursing. We shall not be alone in this task of reconstruction. In many other fields of work old ideas are being discarded and new experiments are being tried. If we have faith in our work and in the world's need of it, we shall not fail."

It seems to me that nursing has been one of the greatest sufferers from "Potterism,"—from shallow, shiftless thinking, on the part of not only the public and of our friends the doctors, but on the part of the nurses as well. There seems to be something about the whole question of nursing which makes it difficult to discuss it in a perfectly impartial, rational way. Even people who are trained in scientific thinking and who otherwise seem quite sane and reasonable, will become dogmatic, confused, or sentimental when this subject is brought up. They are apt to be either dead *for* us, or dead *against* us, either uncritical champions or unscrupulous opponents. The atmosphere of discussion becomes charged with emotion, and then we are apt to get those electric storms which overflow into the newspapers with their blasts and counterblasts of accusation and protest, personalities and prejudices, everything but clear-cut facts and logical reasoning.

What can we do about it? Many people feel that it is best to ignore falsehoods and let them die out. But the trouble is they don't die. The same old lies go on circulating year after year, and worse, perhaps, are the hazy half truths which often deceive even ourselves. The difficulty is not, as a rule that people intend to mislead or to misrepresent facts, they are simply unable or unwilling to think the thing out straight. If we were more familiar with the laws of logical thinking and were determined to trace down every fallacy, to face the facts as they are, whether they are for or against us, and to keep our heads and our tempers, in discussion, we should soon get rid of the dead weights of tradition and misstatement which are hampering our progress; and we should have much stronger support from the public in all our efforts to promote nursing education.

I shall take up only a few of the common fallacies which all of you have heard, I am sure, hundreds of times. But first let us see what a fallacy is. Those of us who studied logic in the old days remember the historic example: "All men are liars. John is a man. Therefore John is a liar." Without going into the question of major premises and minor premises and all the varieties of error which may creep in, we will remember that fallacies are usually logical conclusions resulting from false or partially true statements, or they are conclusions arrived at from correct facts by a wrong process of reasoning. One of the commonest mistakes is reasoning from the particular to the general; as, for instance, in a statement like the following: "This woman has a college education. This woman is not a good nurse. Therefore, women with a college education do not necessarily make good nurses."

Everybody is apt on occasion to draw generalizations from their own limited personal experiences. You are all familiar with the argument that starts this way: "There is something wrong with the training of nurses. Now I had a nurse once——" then follows a long list of individual grievances against an individual nurse for which our whole system of education is indicted.

Old Traditions Difficult to Break Down

The soundest reasoning will make slow headway against a deeply rooted conviction or prejudice which is sanctioned by age or which conflicts with vested interests The suffragists had their hardest task in breaking down

*Read at annual meeting of Massachusetts State League of Nursing Education, Boston, June 1921.

the age-old tradition that men are naturally superior to women, that women exist mainly to serve the comforts and purposes of men, and that men know best what is good for women, whether in politics or education or domestic life.

I am not sure that this feeling is entirely eradicated yet, in spite of the recent political emancipation of our sex. I am inclined to think that it is still pretty strongly intrenched in the rank and file of the medical profession, and that it tends to color most of the discussions which we have been hearing recently about the function and the education of nurses.

Before discussing some of these questions which involve the medical profession, I want to make it perfectly clear that I have the greatest respect and admiration for medical men (and women) as a group, and a real personal affection for many as individuals. Any criticism which may appear in the following discussion is not directed against the medical profession as a whole, but against certain assumptions and statements which medical men are still circulating and which some of them doubtless believe, but which have, to our minds, no rational basis. These common misconceptions about the relation of nursing and medicine not only cause a great deal of unnecessary friction between physicians and nurses, but misrepresent the nature and scope of the nurse's work in the public mind and keep numbers of splendid women out of the nursing profession.

How many have heard statements something like this? "The nurse is the physician's assistant. She exists to carry out his orders. Therefore physicians ought to know what is the best kind of training for nurses, and should control and direct that training."

Nurses Exist for Service of the Patient

Let us see where the trouble lies in this familiar fallacy. In the first place, I think it will be agreed that nurses exist, not for the service of the doctor, but for the service of the patient and of the public generally. The physician exists for the same purpose. Both are trying to make sick people well, to relieve suffering and to prevent disease. But they have different functions to perform. The doctor diagnoses and prescribes and gives some treatments himself. The nurse cares for the patient's needs, conserves his strength, nourishes him, observes his symptoms and carries out many of the treatments prescribed. Each occupies a different circle, and the circles overlap somewhat. The responsibility for the (medical) treatment of the patient lies with the physician and there must be no question of divided policies there. The nurse is the physician's assistant in this, but she is much more, for nursing is a distinct art in itself. If anyone doubts, let him remember the conditions of sick patients before Miss Nightingale made her discovery of the laws and methods of modern nursing; or let him study the situation in several countries today, where scientific medicine flourishes but modern nursing is practically unknown. The mortality statistics tell the story.

In many cases of which we all know, the medical treatment is practically nil—it is the nursing which brings the patient through. It is useless to pretend that the physician indirectly brings about this result, that he gives the orders and the nurse simply carries them out. Consider the case of patients in a hospital, the provision for their comfort, their food, light, and air and all the other things which mean so much in recovery, the constant attention to their needs, the observation of changes in their condition, the prompt treatment in emergencies, the handling of all those subtle psychological situations which so directly affect the total result. How much of this is directly initiated or controlled or even thought out by the physician. It is simply taken for granted and the result too often attributed to medical skill. Or take the visiting nurse whose work in the poorer home, one of our New York physicians calls "a daily miracle." Certainly, she sees that the prescription which the doctor leaves is filled and cooperates with him in every way, but is this all she does before she leaves that home? In addition to actual nursing care, sanitation, domestic economy and assistance to the physician, modern nursing includes a good deal of teaching and social service and community organization. Is this also initiated by the physician? Is it not the outgrowth of nursing, built up and maintained almost entirely by nurses themselves?

Why Should Physicians Control Nurse's Training?

The fact is that the modern doctor knows little more about the details of the nurse's work than the father of a family knows about the management of a household and the care of children. He knows what good nursing is and its results, but he is not skilled in that particular art. He prescribes it as he does massage, or diet, or drugs or dentistry, but that does not mean he himself is skilled in the art of massage, or dietetics, or pharmacy or dentistry. Why should he seek to control the education of the nurse any more than he does the education of the dietitian or social worker or dentist or occupational therapist who also cooperates with him in the treatment of the sick? The physician should be consulted about the nurse's training in so far as it touches on the treatment of disease, and should assist in the teaching of these branches that are distinctly medical in nature. We are always glad to have his point of view about the training of nurses, if it is based on a real understanding of our work. But the job of training nurses must be in the hands of nurses just as the job of training teachers belongs to teachers. This idea is not new. It is the foundation stone on which Florence Nightingale based her whole system and wherever this rule has been departed from there has been failure.

Is All Nurse's Duty Really Nursing?

This brings us to another phase of the question which has caused heart burnings among a good many nurses and has created a very false idea of the nurse's position in the eyes of the public. Because the nurse assists the physician in certain treatments and because she carries out his directions in regard to the medical care of the patient, is there any reason why she should be expected to act as his personal attendant and wait on him hand and foot? The simple little phrase "follow the doctor's orders" has been interpreted in many cases to mean excessive demands on the nurse's service for things which have little or no relation to the patient or to nursing work at all. The terms so commonly used in hospitals, "waiting on the doctors" or "working for Dr. So and So," shows to what extent nurses themselves have accepted this idea. Let us be quite frank about it. Is all this fetching and carrying really nursing? Does it help the patient or does it take from the time required for his care? Does it add to a nurse's self-respect or help in attracting the better type of young women into our work? Would it be entirely dangerous and revolutionary if, at present, when nurses are so overburdened with the care of patients, we should try the experiment of allowing physicians* (especially the younger ones) to wait on themselves a little more? It is being done in families with pretty good results. The old type of domestic autocrat who used to have a whole retinue of

* Who have done the nursing, and the attendance and "all the chores" on a thousand head to the field

women folk dancing attendance on him, is fast disappearing and the relations of men and women are all the better for it. People used to say that if we got rid of the word "obey" in the marriage service, it would destroy the harmony of married life. But has it? Would it destroy the best kind of cooperation between doctor and nurse if we decided to call the nurse a "partner" or a "colleague" of the physician and treat her as such?

Modern Woman Wants to Use Her Brains

The modern young woman wants to preserve her own individuality in her professional life just as she does in married life. She does not relish the "humble handmaid" attitude. She is not willing always to shine in the reflected glory of someone else. She likes to use her own brains a little now and again and to feel that she has some contribution of her own which is recognized as hers, not as a by-product of some one else's achievements. Is this unreasonable or unnatural?

One would gather from many of the newspaper articles and graduating addresses one reads and hears that there is not much premium put on intelligence in nursing. I heard an eminent Boston physician say a few years ago, "The nurse is the extended hands of the physician." (No brains necessary, you see—she has a motor function merely.) Another of our well-known New York physicians in a graduating address said to the group of nurses, "Remember the nurse is only the private; the doctor is the officer. It is not for her to question. It is for her to obey." In a recent report I found this interesting comment on our educational system: "The nature of a nurse's work as ordinarily understood does not call for much initiative or independent judgment; on the contrary, she must learn to carry out instructions. There are certain inhibitions which must become a part of her professional consciousness and behavior if she is to prove successful in her bedside work."

High Grade Morons Would Do

Is it true that nurses do not need to know or to think, only to tread a routine path which is laid out for them by someone else? If so, we do not need to look much farther for an explanation of our present scarcity of candidates. High grade morons would do quite as well as high school graduates, and we ought to make it perfectly plain to any intelligent young woman who wishes to enter the nursing field that her hands and feet will be needed and the lower centers of her brain and spinal cord, but the rest of her brain might as well be put in cold storage.

As a matter of fact, we all know that nursing does require brains and good brains; that there is ample opportunity in any good nursing school to develop one's faculties of judgment and initiative, and that doctors, whether they admit it or not, rely tremendously on the nurses's judgment—(they usually call it commonsense)—and on her ability to do the right thing at every turn of a constantly changing situation. But why not come out frankly and say that the nurse is the doctor's team-mate and not an automaton; that doctors and nurses need to pool all the brains they have to do the right thing by their patients, and that nursing schools as well as medical schools should aim to bring out and develop the intelligence and initiative of their students rather than to repress it.

Industrial experts are just beginning to realize the tremendous loss of working energy which has resulted from the present autocratic system of management in industry as well as the loss to the individual himself from the crippling of his faculties and the lack of adequate self-expression through his work. It is interesting to notice that even in military training we are beginning to see an entire change in point of view in relation to discipline. "Theirs not to reason why, theirs not to make reply, theirs but to do or die," may be good poetry but that kind of a person is not in much demand in modern warfare or anywhere else except in tending automatic machines.

The biggest question is whether we have any right to induce any young man or woman to enter any branch of work where they will not be allowed to grow and to have free expression for the gifts of mind and spirit which they bring. If I felt that nursing would cramp a young woman's personality and build up artificial bars to curb her mental powers in their natural development, I should not advise her to go into this field. I cannot accept the idea that there is anything inherent in nursing, any more than in teaching or motherhood which requires a sacrifice of one's intellectual life or a crushing of one's individuality. On the other hand, I know of no branch of work which has greater potentialities for the development of all sides of the individual, provided, of course, one has the taste and aptitude for it. Can we afford to let these old vestiges of military discipline and medieval asceticism repel the best type of young women we have in our schools and colleges today?

I had a personal experience not very long ago in this respect. I have a bright young niece who has always said she wanted to be a nurse. I have encouraged her to feel that this is a very fine thing for her to do. But since she has been at college I have noticed a little cooling off in her desire. She wrote to me recently and enclosed a copy of one of our widely circulated nurses' pledges with this little clause underlined, "I solemnly swear that I will be loyal to the physician under whom I serve as a good soldier is loyal to his officer." And she asked, "Is a nurse never allowed to think or act for herself? This is what I object to in nursing." Evidently her professors and friends have been urging her to give up the idea of nursing, thinking that she would be throwing away a good education and wasting her ability in a purely routine obedience to the orders of others. It took me some time to convince her that we are not all "dumb driven cattle," that we do have a chance to use all our talents in our own field, especially in the newer branches of educational, administrative, social and public health work. The military analogy is I think, unfortunate and misleading. The relationship is not that of officer and private. Should we not drop the phraseology and some of the unmeaning and rather humiliating observances which go with it?

Medical Profession Has Reserved Rights

This brings us to another fallacy, perhaps we should call it a complex, which has broken out repeatedly in recent years. A psycho-analyst would probably find little difficulty in getting at its hidden roots. The argument is rarely stated plainly but it runs something like this: Medical students study anatomy, physiology, bacteriology, chemistry and several other sciences which are essential to medical practice. If nurses study these subjects, they will naturally assume that they may also practice medicine. Therefore, nurses should not be allowed to go beyond an exceedingly elementary knowledge of these subjects. One might assume that the medical profession had obtained the exclusive right of way in the whole field of the biological and physical sciences, and that it had the right to arrest anyone straying beyond the outside margin of this field and to convict her as a sort of professional poacher.

Now, we all know that there are a number of other professions which claim a right to study anatomy, physiology, bacteriology, chemistry, etc., and that they go pretty deeply into these subjects without in any way injuring the practice of physicians. Students in domestic science, agriculture, physical education and a host of other fields derive their principles from one or all of these fundamental sciences. Moreover, students in many of our colleges who have no professional responsibilities at all study these sciences, sometimes for years, for the educational value that is in them. Why should there be such a hue and cry when nurses, who are working constantly in a world of bacteria, who are responsible for the care of all kinds of broken down human machines, attempt to understand the mechanism entrusted to them and the dangers that beset it? Many high schools have better courses in chemistry and bacteriology than have been admitted to some of our nursing schools. Domestic science students who are preparing to teach public school children, know far more about the chemistry of food and the principles of nutrition than nurses who are caring for patients whose lives often depend on the way in which they are fed. Scientific farmers, whose interest is in crops and animals and butter making, have extensive courses in bacteriology, while nurses who are handling contagion every day of their lives are allowed possibly a few hours of lectures and are lucky if they ever handle a culture tube or see a slide under a microscope.

No Other Profession Has Limits Set

No other profession is hampered in this way when it wishes to strengthen its foundations and to extend its knowledge. No one speaks of the dangers of over-education for the teacher or the lawyer or the engineer. Everybody professes to believe that universal education is the surest foundation for a democracy and we boast with great pride of the opportunities for education which are open to all in this country without reserve. And yet, here is one group of people (not a whole profession by any means) which says to another group, "These are *our* subjects. You can't put them into your nursing curriculum (except in homeopathic doses), because if you do, nurses will know too much; it will spoil them; they will be overtrained; first thing we know they will be stealing our practice."

Just what ground is there for this bogey of nurses practicing medicine? We hear of osteopaths and chiropractors and Christian Scientists (who surely never studied bacteriology and anatomy) diagnosing and treating sick people, but how many nurses have ever done it? Who is most likely to assume responsibility for prescribing popular remedies, the average lay person or the average nurse? Does the study of these sciences in a fairly thoroughgoing scientific way tend to encourage amateur dabbling in medical practice or does it not? If any nurse wants to practice medicine, there is no reason why she should not take a medical course as many women do, but most of us prefer our own job. We think we can do our best work for sick people and for the community as nurses, but we want to be intelligent, competent nurses and we believe that we cannot carry our present responsibilities, or follow up the opportunities which lie before us in our own unchallenged field without sounder knowledge.

Fortunately we have a great body of intelligent people back of us who believe in education and are not afraid that it will ruin our usefulness. They are quite willing to agree with our reactionary friends that "A little knowledge is a dangerous thing," but they add, "The only cure for this is more knowledge." There is a danger, of course, that we may choose the wrong kind of knowledge for our special purpose, or that we might not balance off our theoretical knowledge with the right kind of practical application, or that we might ignore some other phases of training which are equally essential. But these are details of method which must be worked out. They do not weaken the fundamental argument that nursing is based on a number of sciences, just as medicine and other professions are, that nurses have just as much claim to a knowledge of these sciences as any other group and that unless this foundation is soundly laid, we cannot do our work intelligently or well.

Gradually we shall make people see that nursing is not elementary medicine, or the R.N. a sort of half way house to the M.D. They don't lie on the same track though their lines do run parallel a part of the way. Ambitious young women will soon begin to realize that nursing will carry them as far as they can go along any one of a dozen radiating lines, but that an extension of nursing education does not carry one into medical education, nor does a super-nurse mean a mediocre physician any more than a super-woman means a mediocre man. Eventually the public will realize that people who are recognized authorities in medicine and surgery do not necessarily know everything about nursing any more than nurses do about medicine.

Well Educated Persons Will Go Farthest

There is another fallacy which we hear sometimes from both nurses and physicians, and it is not at all peculiar to them because the public generally is apt to feel the same way about many other branches of education. It is that knowledge (theory, they usually call it), makes people theoretical, while practical work (experience) makes people practical. Another way of putting it: The better your education, the less practical you are likely to be. This idea has existed for many years in industry and in business, but it is fast giving way before the actual achievements of numbers of college men and women who are now in great demand in practical business enterprises. Where rule of thumb workers only are needed, education does not matter so much, but where adjustments have to be made and new ideas developed, the most practical person in the end is the one with the most resourceful, most flexible mind, the one with the most usable knowledge, and with the soundest body of principles. Other things being equal, the person with the best education will do her work more intelligently and safely, will advance more rapidly and will accomplish more than the one with little. She may be a little slower in acquiring skill, that is a matter of practice. She may lack some essential qualities of character or spirit, and in this case she would inevitably fail in any field of work in spite of her knowledge or skill. After all there are three sides to the good nurse, all of them essential, and if any one is weak you cannot get a symmetrically developed product. One is the knowledge or "science" side; one is the practice or "skill" side, and one the feeling or spiritual side which gives us the spirit of service, the sympathy and the social vision required in all good nursing work. The point I want to make is that the strengthening of one's knowledge does not weaken practical skill or nursing spirit—it balances the whole structure. The old adage that experience is a good teacher is still sound but we might supplement it by saying that experience plus organized education is a much better teacher and carries you to your goal much more rapidly and with less waste of effort.

There are many other cherished illusions which we

might find to be equally unsound if we examined into them a little more closely. I have some hesitation in questioning this last one for fear some of you may think it a little sacrilegious. It is one of the corner stones of our faith and though I believe it is fundamentally sound, I think we have used it frequently in a wrong sense and sometimes carried it so far that we have done serious injustice to our students. "The patient comes first," has been almost the first commandment of nursing. It is indeed the primary aim of every hospital worth its name, and nurses have done more than any other group to build that idea into the modern hospital system. But the hospital has assumed a second responsibility which is the education of a body of professional women, and it has admitted students to its school on the promise that they shall be given a fair return for their service in terms of education. We are beginning to wonder if it is possible under our present system to combine these two functions in any satisfactory or equitable way, but if the hospital assumes the obligation should it not carry it through? I am afraid that at the present time it is the student body which usually shoulders the burden and pays for the deficits.

A hospital superintendent told me with great indignation the other day of a dying patient who had been left alone because all the student nurses were at class. The fault of course was the nurses'. "Patients must come first." Do you see where this leads? No one would hesitate to interrupt any kind of educational work to meet a special crisis, but emergencies involving life and death are every day occurences in hospitals and must be planned for without drawing so heavily on the student's time and strength and undermining her fundamental preparation for her life work. How would medical students get their training if the same rule were applied from the beginning to them.

Students Demand Broad Education

A superintendent of nurses told me not long ago that she feared student nurses were losing their fine old spirit of devotion to the patient. I found that some of them had protested because they had been put in a long service on a chronic ward and had missed a number of things—particularly their pediatric experience. She said very sadly, "They think more of their training than they do of the sick patients." Were they entirely wrong? Were they not justified in asking that their training should be as broad and complete as possible in order that their future service to sick patients might be the better? Besides, are they not paying for their training and should they not get a fair return, even if the hospital has to employ additional service to provide for the care of its patients?

As far as the superintendent of nurses is concerned she is on the horns of a perpetual dilemma, constantly torn between her anxiety for the patients and her desire to do justice to her student nurses. Some adjustment can doubtless be made without sacrificing either, but the question is whether any person can serve both masters with absolute faithfulness.

You will think of a great many other fallacies which I have not time to touch on. For instance, "Better education for nurses means more expensive nursing service; low educational standards mean cheap nursing service." Or this: "The better you educate nurses, the less they will want to do. If you give nurses university training they will be no use for practical work at all." We have abundant proof to confute both these statements, but the general public is apt to be misled by them as well as some of our own friends who should know better.

Overhaul Old Ideas

It seems to me that we could do no better service for our profession just now than to overhaul all our old ideas and traditions and see how many of them can be justified by facts and by logical reasoning. Then we might collect all the current statements we hear about nurses and nursing and submit them to the same test. Finally we should make a united effort to meet false statements with facts, and fallacies with logical arguments. Don't let us be afraid to admit that we sometimes have been mistaken ourselves, that we have often followed in beaten baths without knowing why, and have accepted the decisions of others about our work because we had not the courage or the will to think for ourselves.

This is a critical period in nursing education and we must see clearly and build wisely if our work is to stand for the future. The first essential is that we should clear the ground of the old outworn or unsound timbers which are giving way under the strain of modern demands and the spirit of a new age. Then we shall be better prepared to rebuild our structure using the best materials and a sounder foundation, fashioning the whole plan on broader lines to accommodate the widely varied activities of our modern profession of nursing. We shall not be alone in this task of reconstruction. In many other fields of work old ideas are being discarded and new experiments are being tried. If we have faith in our work and in the world's need of it, we shall not fail.

HOSPITAL FOR CRIPPLED CHILDREN OFFERS POSTGRADUATE COURSE

Realizing the increasing demand for nurses' training in orthopedics and pediatrics the Minnesota State Hospital for Indigent Crippled and Deformed Children, Phalen Park, announces that it is now offering a course for postgraduates and affiliates. The course covers a period of from two to six months, especially emphasizing physiotherapy which plays so important a part in the treatment of infantile paralysis cases, orthopedic surgery, infant feeding, occupational therapy, dispensary and out-service department. The state hospital is well equipped with all modern and up-to-date appliances and has a capacity of 200 beds. Each department is supervised by women who have had extensive training in their particular line of work. Nurses and hospitals interested may address further inquiry to the superintendent.

GOD MADE A NURSE

He made her heart brave, true, and kind,
And like His mountain streams her mind:

As crystal-pure, yet swift or deep
As where their waters rush or sleep.

Her hands He made firm, tender, skilled;
Their touch with His own pity filled.

And gave, to make His nurse complete,
A sense of humor, wholesome, sweet.

God made a nurse—Thank God!

—Selected.

"Not to offend by the smallest physical act in the performance of nursing procedure, should be the nurse's constant concern."—Aileen Cleveland Higgins.

Dietetics and Institutional Food Service

Conducted by Lulu G. Graves,
Director, Dietary Department, Mt. Siani Hospital, New York.

THE MEATLESS DIET

By LOUIS J. FRANK, Superintendent, Beth Israel Hospital, New York City

IT IS not the purpose of the present communication to make a plea for a new fad in dietetics. Most likely the foods used by man since time immemorial have been conducive to his health and contentment. An attempt to induce human beings to forego certain food ingredients for esthetic, economic, religious, or humanitarian reasons may have such justification for their exclusion from the dietary. But it is doubtful that there are any physiologic or biochemic reasons for the prohibition of proteins or fats, simply because they are derived from a certain source.

The Brahmins and Buddhists, who believe in the transmigration of souls, cannot, of course, recommend the eating of animal flesh. Nor can the sensitive human being who abhors the infliction of pain to dumb brutes partake of flesh obtained by slaughtering these animals. One cannot argue scientifically against esthetic, ethical, or religious convictions, and as far as the individual goes, these reasons hold. But when blind partisans state that meat is harmful because it causes cancer, for example, the burden of proof lies with them, and they certainly have not proved their point, except in an evidently prejudicial manner. For example, the vegetarians state that because of their abstinence from meat the native Africans do not suffer from malignant neoplasms. They could also have stated that the Eskimos, whose diet is based mainly on flesh foods, are as immune to cancer as the Africans.

Digestible foods, fats, proteins or carbohydrates, if assimilable, are equally nutritious, no matter what their source. Whether protein comes from nuts or chicken or cheese or herbs, it is protein, and if it can be absorbed and metabolized without the formation of toxic by-products, this protein has equal food value. So far as nutrition is concerned, herbs are as good as meat. The Bible says, "And God said behold, I have given you every herb bearing seed which is upon the face of the earth, and every tree in which is the fruit of a tree yielding seed; to you it shall be for meat." This was written a long time ago, but it is still good dietetics.

Meat Not Necessary Scientifically

Scientifically, one cannot say that meat is a necessary ingredient in the human dietary. There are those who are convinced, on the contrary, that meat is not beneficial, or is even harmful. Granted, therefore, that a meatless dietary is as good or even better than one containing meat, why not investigate to see if there are other reasons for or against a meatless dietary?

It must be remembered that in this paper I mean by the word "meat" the flesh of mammal or fowl, but not of fish.

There are certain reasons why a meatless diet is advisable in a hospital such as ours. Those who are acquainted with the Mosaic Law are aware that it is prescribed in the Jewish ritual not to mix meat and milk and their derivatives. The origin of this custom is based upon the bidding of Moses not to seethe the kid in its mother's milk. Upon this ruling the biblical commentators, the gaonim and the rabbis, etc., have based the whole system of dietetic ritual. Meat may not be eaten with butter. Chicken flesh may not be cooked with milk, or butter, or cream, or cheese. Nor may a utensil that is used for "milk" foods be allowed to serve as a "flesh" container. That is, for example, a knife used for the spreading of butter may not be used for cutting meat. A pot in which meat or chicken has been cooked, or in which a derivative of these foods, as for example, beef fat or chicken fat, has been contained, may not serve for cooking milk or holding cream, etc.

The Beth Israel Hospital, however, was created so that the orthodox Jew may have a haven in time of illness, for whereas the reformed Jew or the Gentile may eat anything that suits his palate, the orthodox Jew will forego health, and life itself, rather than partake of food procured not in accordance with the ritual, or served in utensils, etc., not kept for special kinds of food. In order to please this class of patients it is, therefore, essential that separate kitchens, preparation rooms, dish washing room, sculleries, etc., should be provided which, in a hospital such as ours, means the occupancy of considerable extra space.

From a medical point of view there is nothing inherent in meat that cannot be supplied by fish, milk, eggs, and milk products. The protein, fats, and the little carbohydrates and salts may be easily derived from non-meat and non-poultry substances.

Until recently it was surmised by some that meats are a source of vitamines, but this has been recently disproved by Dr. E. V. McCollum, professor of chemistry and hygiene, Johns Hopkins University.

The prejudice and taste of a majority of the people are, of course, for a meat diet, but not because of any true benefit that they derive particularly from it.

Advantages of Meatless Diet

In a "kosher" institution, the following advantages of a meatless diet present themselves.

1. Religious: Certainty of "koshers."

2. Hygienic: Less space to clean; easier to keep clean with no meat; less odors; less garbage.
3. Administrative: Will cater to all—not only to orthodox Jews; will permit a greater number of dishes; will attract those patients to whom a lacto-vegetarian diet is suitable: nephritis, gastro-intestinal diseases, arteriosclerosis, rheumatism, cardiac diseases, etc.; will attract pregnant women who have some gastro-intestinal, hepatic, nephric derangement, etc.; will attract the great majority of human beings because of the diet; will be able to stock up with canned and dehydrated foods in cheap seasons; the workers, after their meals, will be satisfied to a greater extent than they are now, their stomachs will not be overloaded, and they will be able to work better.
4. Educational: Will teach people the value of foods properly cooked, etc.; will teach the value of vegetables.
5. Economical:

(1) Saving Space: Kitchen (one room for all diets instead of separate rooms for "meat" and "milk" diets); preparation room (one set of rooms instead of two, for same reason); refrigerating room (not necessary to provide for separate "meat" and "milk" compartments); scullery (one room instead of two); dish washing rooms (one room instead of two); "trebering" room (this room would be necessary to prepare meat in conformity with the Mosaic Laws, and can be saved if no meat is used); serving rooms (none will be necessary, since all can be served direct from the one kitchen); dining room (a better arrangement, permitting grouping around one kitchen, otherwise a corridor is necessary to bring food from each kitchen, depending on the meal); cupboard (only one set needed under the non-meat system).

(2) Saving of Equipment: Cutlery, crockery, glassware, pots and pans, outfit of a complete kitchen, outfit of a complete dish washing room, outfit of preparation rooms, housekeeping supplies, etc.

(3) Saving of Light and Gas: For general illumination, for cooking, for heating.

(4) Saving of Help: No "treberer" needed, fewer kosher supervisors, fewer cleaners, less help required because of the lack of necessity to handle heavy quarters of beef.

Disadvantages Refuted

The following seeming disadvantages may be refuted as noted:

1. Necessity for special cooks, etc.; the entire institution will be managed by experts, and just as it will be necessary to secure expert doctors, expert nurses, expert clerks, etc., it will be necessary to secure expert dietitians and expert cooks.
2. The diet may be unsatisfactory for the help, the doctors, and the nurses; I believe they all will be satisfied with the food properly balanced and prepared by expert dietitians and cooks. If they are not, we will pay them to eat out.
3. No provision for that rare patient who will insist on meat; meat, as well as any other interdicted food, will be served upon prescription of the doctor.
4. Expenses may be greater; I do not agree to this, but should the expense be greater, it will be overbalanced by the certainty of the "koshers," for we are going to a great expense to maintain a "kosher" institution, and if a little more money will make that assurance doubly sure, the additional expense is well worth while. In fact, it is mandatory.
5. Necessity for a small campaign of propaganda to overcome criticism of the ignorant; the hospital will be a teaching institution, and it is just as important to teach good food habits as anything else; in fact, more important.

WHY STEAM TABLES?*

Why do we find steam tables in the main kitchen of so many hospitals? In the majority of hospitals food for ward service is transferred directly from the range to a food cart or whatever conveyance is used in taking it to the wards. Using a steam table for this service means one extra handling of food. This is detrimental to the food and consumes valuable time.

The same principle holds for service to the nurses' and doctors' dining rooms.

If the employees' dining room is near the kitchen, and service there is direct, a steam table may be a convenience, but a small or medium-sized table is sufficient.

In fifty-seven hospitals visited during the past year, an appalling number of unused steam tables were seen—appalling when one considers the expense of this piece of equipment and when we think of the amount of unnecessary walking which it implies.

Usually a steam table is placed near the range and in the direct path of travel. All day kitchen employees must walk around it. Even if it is used at all, it is used only at meal times for a short period. Is there not some less expensive and more convenient way of meeting the service to employees' dining rooms?—THE EDITOR.

*This is the first of a series of queries which will be a regular feature of the Department of Dietetics and Institutional Food Service for a number of months, depending on the interest which the questions arouse. Discussion is invited, with a view to summarizing and publishing in later issues of the magazine the opinions of dietitians, hospital superintendents and others.

Lacto-Vegetarian Diet

To us it appeared self evident that a lacto-vegetarian diet which permits the use of fish and fish products can be made well balanced and tasteful. In order to appease the fears of the medical profession and the superstitions and prejudices of the lay public, we decided to obtain authoritative confirmation of our opinion, and Dr. Max Kahn, director of the department of laboratories of the Beth Israel Hospital, addressed the following letter to Professors F. G. Benedict, Russell H. Chittenden, W. J. Gies, Graham Lusk, Lafayette B. Mendel, E. V. McCollum, and Victor C. Vaughan, the most prominent biochemists, metabolists, and physiologists in America:

I have been asked by the president and board of directors of the hospital to obtain your opinion whether it is desirable to institute a vegetarian and dairy dietary in the wards and pavilions of our hospital.

We are especially interested in this matter from the following point of view. In our hospital strict adherence to the Mosaic dietary regulations is enforced. Now it is very difficult, and at times impossible, to be sure that the religious interdictions are strictly adhered to. If, therefore, we could establish a meatless dietary, the question of the religious ritual would be settled.

We wish your opinion, if you will kindly give it to us, as to whether it is possible to prepare a well balanced

meatless diet which would also contain the vitamines and salts so necessary for nutrition. Please also take into consideration that fish and fish products—exclusive of the shell fish—would be permissible under our conditions.

Their answers follow:

From Francis G. Benedict, director, Carnegie Institution of Washington, Nutrition Laboratory, Boston, Mass.:

Your problem is not very simple. What is the average sojourn of your population? Are there children? Are the hospital attendants on the same basis? All these points need to be considered.

Milk is almost an absolute necessity for growing children. My good friends at the Battle Creek Sanitarium would, I am sure, assure you that your project is hygienically and physiologically sound.

Looking out for the food accessory substances, I should be quite inclined to feel that your plan was a safe one.

From Russel H. Chittenden, Sheffield Scientific School of Yale University:

In reply to your letter of June ninth, I beg to state that in my opinion it is quite possible, and indeed a desirable thing, for many reasons, to establish a lacto-vegetarian dietary in the wards of your hospital. There is no question in my mind that such a diet can be made nutritious and healthful. I suppose you can supplement it by eggs, if necessary. Further, the addition of fish gives you a wide range. But with vegetables of all kinds, with milk, bread and butter, you have at your command all the necessary resources for a nutritious diet.

From William J. Gies, Columbia University, College of Physicians and Surgeons, Department of Biological Chemistry, New York:

I am satisfied you would have no particular difficulty in maintaining satisfactorily a meatless diet that would be well balanced and satisfactory in all respects, including the necessary kinds and proportions of vitamines and all other necessary nutrients.

From Graham Lusk, Cornell University Medical College, Department of Psychology, New York:

I believe that the lacto-vegetarian diet could be established in any hospital without detriment to the health of the patients. It would be well to provide green vegetables or spinach so that iron could be taken in this form. Of course, as you know, a milk diet was long the only support of typhoid patients.

From E. V. McCollum, the Johns Hopkins University School of Hygiene and Public Health, Baltimore, Md.:

I have not the slightest hesitation in saying that vegetarian diet, supplemented with fairly liberal amounts of milk, is the most satisfactory type of diet than man can take. I do not advise the elimination of meat from the diet because of its palatability, but that it is necessary for optimum well-being I do not believe. The use of fish and fish products can be utilized to accomplish the end of increasing the attractiveness and palatability of the foods almost as well as meats. I feel that you would be entirely safe in adopting this kind of diet and that you would be doing much better by your patients than is now being done in many of the best hospitals in the land, where patients are attempting to recover from wasting diseases or from surgical operations on diets of the cereal, tuber, and muscle meat type. Palatable and attractive as they may be, I feel confident that they are not very satisfactory as human foods when adhered to over appreciable periods.

In case you adopt this new plan I shall be greatly interested to follow its development and to learn whether you meet with any esthetic problems in connection with the feeding of your patients.

From Lafayette B. Mendel, Sheffield Laboratory of Physiological Chemistry, Yale University:

I have given some thought to the advisability of introducing a meatless dietary into your hospital régime, and reached the conclusion that there will be no objection to this upon physiological grounds. Inasmuch as I myself lived upon a diet devoid of meat, fowl, and fish for nearly a year, for purely experimental purposes, and remained in excellent health and vigor during that period, I have no fears regarding the wholesomeness of such a procedure.

If we consider the various aspects of the meat-free régime, the foremost criticisms will probably be as follows: (a) The ration tends to be low in calories. It is true that on a vegetarian diet the food intake is likely to be reduced for a variety of reasons, because the ration tends to become less palatable than in cookery with meat products. However, with fish, milk, and eggs permitted, as I assume they will be in the meatless dietary, the palatability can be greatly enhanced. As a substitute for meat stock or extract of beef in preparing soups, gravies, etc.,—all of which are so highly prized in a well flavored diet such as your patients are allowed,—I see no reason why the now commercially available extracts of yeast should not be used. In England "Marmite" is sold for this purpose, and the same product is available in this country under the name of "Vegex." These commercial names happen to be familiar to me, but there are doubtless others, and it is not difficult to prepare a well flavored extract of yeast. Incidentally, it is rich in water-soluble vitamine. (b) It may be said that the quality of the protein in the vegetable diet is poor. This can scarcely apply where fish, eggs, milk and its numerous products (cheese, etc.) are surely available, as they can be without violation of the Mosaic dietary regulations. As you well know, even small quantities of "animal proteins" serve to supplement well the proteins of the cereals, etc. (c) There will be no lack of suitable vitamine A, B, C, where milk and cream, green vegetables, fruits, and eggs are used in abundance. Surely meat has no virtues as a source of vitamines except in so far as the beef drippings ("oleo oils") may furnish a small amount of fat-soluble vitamine, such as the egg yolk yields in far greater abundance. Incidentally, inorganic salts will be assured quite as well on the meatless dietary, and there will be no lack of suitable "roughage."

If you have ever visited the Battle Creek Sanitarium you will have noted that life is possible and good health is maintained without the use of meat. I regard the diet there as too bland for your clientele, but I am sure the menus could be greatly improved by additions of further foods such as you are not interdicted from employing. Under separate cover, I am sending a few reprints which are intended to support some of the comments which I have made.

From V. C. Vaughn, University of Michigan Medical School, Ann Arbor, Mich.:

I am quite sure that you would have no difficulty in establishing a vegetarian dairy fish diet. You can easily arrange this so that there will be plenty of vitamines and calories. Other meats and other animal foods are, in my opinion, not essential.

A combined meeting of the board of trustees and the medical staff of the Beth Israel Hospital was held to discuss the question of instituting a meatless dietary in that hospital, and two committees were appointed to investigate (a) the scientific aspect, and (b) the economic aspect of the question. The first committee reported the following resolutions:

"WHEREAS, It is not a mooted question that a diet can be prepared exclusive of meat and meat products that will be well balanced and will contain the vitamines and salts essential to nutrition;

"WHEREAS, Such a diet consisting of milk and its derivatives, of eggs, fruits, vegetables, cereals, grains, nuts, etc., as well as of fish, is highly nutritious and satisfactory both to the palate and the stomach;

"WHEREAS, Such a dairy diet has all the advantages and none of the disadvantages of a meat diet, and

"WHEREAS, From intensive study and by correspondence with the leading authorities on nutrition in America the committee has become convinced of the desirability of a meatless diet;

"THEREFORE, It is the sense of the committee that such a diet is scientifically correct."

The committee on economics reported as follows:

"Conceding that the weight of scientific opinion favors a meatless dietary for patients, the hospital economics and the interrelationship of patient, hospital staff, and a hospital furnishing to patients an exclusive meatless diet present these items for consideration.

"A. The prerequisite of an absolutely hide-bound and properly religious adherence to the Mosaic dietary laws would be greatly facilitated and hospital administration simplified by a meatless diet.

"B. It is understood that, by meatless diet, vegetarianism is not implied, fish, eggs, and milk being included.

"Furthermore, it is understood that a properly qualified chef will be employed, so that the diet furnished shall not only be palatable but also shall contain substitutes made from the meatless foods to take the place of meats.

"C. The saving on initial expense in installation of ice boxes and butcher shops and in the employment of butchers will more than allow for provisions, so that the help, nurses and house staff may, at stated intervals, be indulged in their meat diet outside of the hospital.

"D. As far as the ward patients are concerned, no administration disadvantage presents itself that is worthy of consideration.

"E. Private patients of the Jewish faith can enter no legitimate complaint on a meatless diet during the short period in which they remain in the hospital.

"The committee, therefore, feels that, from the administrative standpoint, no disadvantage will accrue to the staff, to the patients, or to the hospital should the board of directors deem it wise to adopt the proposed measures."

The reports of both committees were adopted unanimously.

The "last word" is never spoken on any subject. I do not mean to say that we have irrevocably vowed to have a meatless diet. At the present time, it seems to us that the benefits of such a dietary are numerous and that the patients will especially derive advantage from it. Those who live and think have the inherent right to "change their minds." As somebody has well said, "Perpetual consistency is only an evidence of mental fossilization." However, we have yet to be convinced that there is any good in a meat dietary for a hospital treating acutely ill patients.

REPORT OF THE DIETETICS SECTION OF THE AMERICAN HOSPITAL ASSOCIATION

The Dietetics Section of the American Hospital Association held its meeting on Friday morning, September 16, at 10 o'clock in the convention hall, with Miss Lulu Graves of Mount Sinai Hospital, New York City, as chairman, and Miss Marion Peterson, dietitian of The Swedish Hospital, Minneapolis, Minn., as secretary. This was the first meeting of this section and Miss Graves in her opening remarks said that the dietitians were very glad to have an opportunity of meeting with the hospital superintendents to exchange ideas.

Mr. Street, of Indianapolis, who was to give a paper on "Food Preservation," missed his train and was unable to be present. Miss Eckman, of the University Hospital, Ann Arbor, Mich., read a very interesting paper on "The Dietitian as an Asset to the Hospital," which was published in the October issue of THE MODERN HOSPITAL.

A general discussion followed Miss Eckman's paper. Mr. Pliny O. Clark, of Denver, said he wished Miss Eckman had discussed further the question of the central serving kitchen as opposed to serving kitchens on the floors. Dr. Munger answered this question by saying that they had tried it in the hospital with which he is connected with the result that the food reaches the patient cold and unpalatable. They had also tried the central dishwashing scheme with success, as they feel that there is less chance of spreading contagion in this way. In regard to kitchen sanitation, Dr. Munger further said that he had had two epidemics due to kitchen employees, one of diphtheria, the other of small pox, spreading not only to employees, but to patients. Since then they have required all employees to have a thorough medical examination especially for venereal diseases, and they must be vaccinated, have a Schick test, take typhoid vaccine and have their hands examined regularly for infections, and a watch is kept for colds.

Central Serving Kitchen Successful

Mr. Burch, Philadelphia, Pa., said that they have a central serving kitchen, and have had no complaints as to the palatability and temperature of the food served. Miss Young, of Nichols Hospital, Battle Creek, Mich., reported that they have a central serving room in a seventy-five-bed hospital, and all the trays are served in eight minutes, from the time the food conveyor is brought to the floor, and there have been no complaints. Dr. Howland, of the Peter Bent Brigham Hospital, Boston, told of the system they used in their private pavilion where all the diets are served from the main kitchen in the basement and sent on electrically heated carts to the floors, and this plan has proved very successful. He also said that the man who handles the milk, goes to the assistant superintendent to have his throat and hands examined every morning.

Mr. Chapman, of Mount Sinai Hospital, Cleveland, said that they reexamined everyone in their hospital every sixty days, and the employees in the dietary department every thirty days. In regard to the central serving room Mr. Chapman thinks it is a question of adequate transportation and possibility of keeping the food hot. There were other experiences with central serving rooms cited in which the service seemed to be good.

Dr. Howland, at the request of Mr. Test, of Philadelphia, explained further their system of handling milk. They buy pasteurized milk, which is poured from the containers into porcelain-lined dairy vats, and then is poured off into containers for the different wards as called for on the requisition slips. The milk is tested for butter fat, and bacteria count once a week. The nurses handle the milk after it reaches the wards. The head nurse is in charge of the trays as they are served, and the dietitian makes rounds and gives suggestions.

Dr. Wilson, of New York, suggested that the handlers of food in a hospital should be examined as to whether they are carriers or not. Mr. Test told of the method they have for handling milk. They use one-half pint and quart bottles for their patients and ten-gallon containers in their kitchen.

There was time for only one question which was: What should be the proper title and status of the dietitian? Dr. McEachern, of Vancouver, replied that in his opinion, the dietitian should be the "director of dietetics," and should have complete charge of the food including the determining of the kind, quality, preparation and service. There were fifteen or twenty other very interesting questions sent in, but for lack of time it became necessary to close the discussion. The meeting was very well attended and it is hoped that next year more time may be assigned to this section in order to discuss adequately the many dietary topics of interest to both dietitians and hospital superintendents.

Respectfully submitted,

MARION PETERSON, Secretary.

On account of lack of space in this department the "News Items" will be found on page 439.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

HOW TO SELECT HOSPITAL FURNITURE*

By DUANE WANAMAKER, Chicago, Ill.

THE importance of selecting the right sort of furnishings for a hospital can scarcely be exaggerated. Especially in a day and age like the present when the average man and woman have been taught to expect "service first" in everything pertaining to their welfare, it is practically impossible for a hospital to progress very far or attain any noteworthy standing, unless its equipment is of a very high order. And by equipment, in this particular instance, is meant the furniture which goes into the patient's room and which is placed in corridors, sitting rooms, and other places where its suitability will be put to the test to decide whether or not it offers a maximum of comfort and convenience, and at the same time reflects the correct atmosphere.

That word "atmosphere," by the way, is getting to be more firmly intrenched in the dictionary of successful hospital management, with each passing year. The old-fashioned, gloomy, badly furnished and depressing hospital is rapidly disappearing and the modern hospital is more like a first class hotel than anything else. And why is this true? Because pleasant surroundings and the right sort of "atmosphere" are now recognized as a powerful factor in speeding the recovery of the patient. The right sort of atmosphere can only be attained with the sort of furnishings that will help to create it.

Showing the arrangement and furnishings of a typical private room in the Ford Hospital, Detroit, Mich.

Of course, it is hardly necessary to mention that another thing which has speeded the "better furniture movement" in hospital has been the need for more sanitation and a lowered cost of upkeep, due to the ever increasing cost, and of late the scarcity, of trained workers. This phase of "furniture progress" is taken for granted because there is probably not a single hospital in the country that does not appreciate the convenience and economy of furniture of as good a quality as it feels it can afford. What some hospitals apparently do not appreciate thoroughly, however, is the value of better furnishings in creating the right atmosphere for the patient and in advertising to the world that the hospital is not the doleful place of misery which too many people picture it to be—a place to be shunned except as a "last resort," but rather that it is a sort of auxiliary to the home, where trained service and expert knowledge, together with a homelike atmosphere, will do the utmost good for the patient.

Hospital Should Be Suitably Furnished

This thought was voiced for me by an official of one of the largest and most modern hospitals in the country, who said: "A hospital should not be a barren, bare, desolate place any more than the patient's home should be that way. But, to continue with the simile, the hospital's ability to furnish conveniences and luxuries is limited by certain conditions, just as the patient's own home will, generally speaking, reflect the sort of position he holds in the community. If a hospital handles charity cases to a great degree, it can scarcely offer more than cleanliness and comfort, made possible by substantially constructed but simple and inexpensive furniture. On the other hand, if the hospital caters to the type of people who can afford luxuries, I believe in offering them everything consistent with good hospital management. Naturally, the more complicated your equipment the harder it will be to maintain, because it will take more people and a better than ordinary class of help to care for it. But nevertheless the patient who wants and can afford luxurious furnishings should have them in a hospital, just as he demands and gets them in a hotel. There is no sane reason why this should not be the case, that I can figure out." This same official gave me his ideas in concrete form, as to what constitute the

*The writer of this article wishes to express grateful acknowledgment to officials of St. Luke's Hospital, Chicago; Albert Pick and Company, of Chicago; Berkey and Gay Furniture Co., of Grand Rapids; The New England Furn. and Carpet Co., of Minneapolis, and other friends connected with hospitals and furniture establishments for a host of information used in the preparation of this story of how to equip a hospital properly.

correct furnishings for a hospital, and these ideas, coordinated with some other authoritative opinions which I secured on the subject of modern hospital equipment, will, I believe, prove helpful to any institution about to start up, or considering the installation of new furniture.

First, the furniture for a hospital naturally should be selected, like the furniture for any public building, with a view to the suitability for the use intended. Second, it should be of such materials and workmanship that a maximum of service would be obtained with an economy of upkeep. Third, it should be selected not so much as furniture equipment but as a unit or note in the completed room scheme which, if properly done, should not make it stand out or be noticeable above other things in the complete equipment. In furnishing a hospital room color and form should both be given consideration. It seems that it is best to deal in half tones or quarter tones of color. To be explicit, strictly neutral color effects that will be restful, or at least will not jar the nerves of the most sensitive patient, are preferable. Doubtful carving and other ornamental details should be very carefully handled in furnishing a hospital room, for the reasons just given.

Probably of first importance in equipment of a hospital is the bed upon which the patient must spend most of his hours. Comfort is the first requisite here. There are various satisfactory patented adjustments on the market for lowering and raising the limbs of patients and for providing back-rests, but in general the bed should be basically constructed to provide the utmost restfulness. Iron or brass beds have proven most satisfactory, although a large number of institutions prefer to install steel beds which are obtainable in colors to match the furniture, and which not only fulfill all requirements as regards comfort and economy of upkeep, but also are restful to the eye. The upkeep on brass beds, which a leading hospital uses, has been found to be approximately ten dollars per year. This provides for refinishing at regular intervals and generally keeping the bed in first class condition. The same hospital uses link fabric springs for ward beds and box springs in private rooms. Beds should be at least twenty-eight inches from the floor, so that they can be readily swept under, and also to enable the doctor and nurses to be at ease in giving the patient attention. If casters are provided they should be large ones. It is taken for granted that any bed bought for a hospital should be carefully tested to see that there is no "wabble" or noise to irritate the patient.

Bedside Table Important

A bedside table should be provided in every case, which, if properly constructed, will provide a cupboard for the patient's personal belongings. But if a hospital is handicapped by a lack of funds for giving proper attention to points of cleanliness, it is doubtful if anything elaborate along this line should be furnished. It might be preferable to have merely a small "skeleton" table by the bed to lay things upon which should be either of metal, or wood with a glass top.

The average patient's chair, according to a leading hospital is "an abomination." In fact, it is poorly suited to providing comfort for a sick person. The hospital in question has a well known manufacturer make up chairs according to specification. In general, the chair must first of all be absolutely comfortable, and what is comfortable to the "nth degree" for a well person, testing the chair, is considered comfortable for a sick person. It is difficult, admittedly, to build a chair that will be as well suited to a sick man weighing, say 300 pounds and of a well knit frame as to a short man weighing only 125 pounds, but the general criticism of the average hospital chair seems to be that it is built with a view apparently to pleasing only

The furnishings of the foyer of St. Luke's Hospital, Chicago, Ill., might well be compared to that of a modern hotel.

the light man, of small stature. In connection with this, it may be interesting to quote what a prominent manufacturer says about the easy chairs which they build in large numbers for hospitals:

"Easy chairs for hospital use should naturally be built with a view to furnishing the greatest amount of comfort to the largest possible number of people. Naturally a chair of this type is upholstered. Chairs that we have built along this line have been roomy, first of all, with seats lower than the ordinary ones so that a small person can sit in them with comfort, also so that the seat can be bolstered up with a pillow when necessary. The arms should be flat and restful, they should also be substantial, and should have a sufficient arm hold for the convalescents to raise and lower themselves into and out of the chair. The back should, of course, be high enough for a head rest. Our method of building chairs of this kind has been to upholster them in an inexpensive material and then to make slip covers which fasten smoothly over the chair, and which can be easily taken off and changed. This makes for cleanliness."

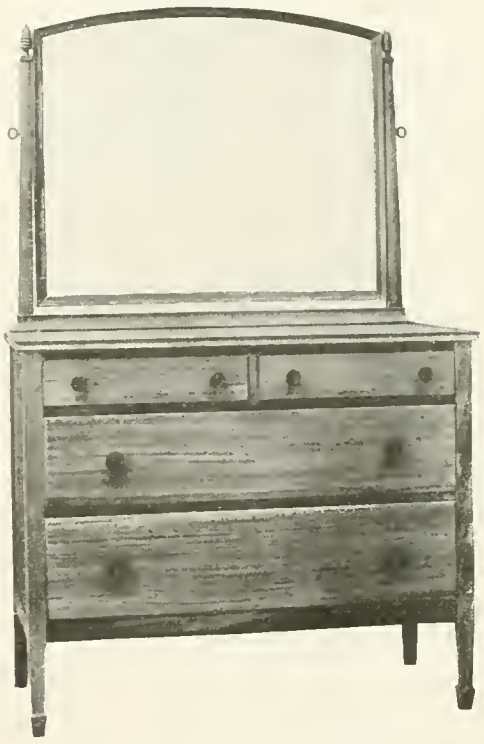
There should be near each patient's bed, a nurse's chair which need not be of any special type, except that it should be comfortable.

Screens are another item which, I have found, are often built in a manner unsuited to hospital use. The favorite type in a prominent hospital is a screen with an aluminum frame, and aluminum insert instead of fabric of any kind. Such a screen is substantial, sanitary, and is much lighter than a screen with an iron frame, for instance. Stretchers used by the same hospital are of the four-wheel type with a rubber tire run around the top so they won't bang into and dent other objects, at the same time obviating any jars.

The foregoing has been chiefly concerned with the furnishing of wards which may contain any number of patients. Though it applies to a considerable degree to the furnishing of private rooms, as well, what a Chicago hospital of national reputation specifies with regard to furnishing a private room, in detail, should be of interest. In general, a private room should be outfitted like that in a hotel, offering the patient just as much comfort, and luxury even, as is consistent with successful hospital operation. The bed should be along the same lines as previously outlined, but an added reason may be named here for having it at least twenty-eight inches from the floor. This is to provide for a nurse's cot which can be pushed under the bed on occasion to provide more room, or to give the room a more open and cheerful appearance. The cot should be a simple affair, with an iron frame. In it should be set a box spring, with hair top, and it should be suited to sleeping, or sitting upon in the daytime.

A chair especially suited to invalids, preferably a reclining chair, should also be provided. A bedside table, with cupboard not only for holding the invalid's belongings but also with a receptacle for storing the various small utensils needed by the doctor and nurse in dealing with this particular case, should be furnished. An old colonial or spinet desk in mahogany, is considered good taste and a dresser of the same wood should be an important part of the equipment. Besides the bed table, a center table preferably of gate-leg type is advisable to provide a place for a large vase, books, etc., and to allow the patient and visitors to play cards, etc. A portable lamp also should be furnished. Plenty of comfortable chairs, to match the rest of the furnishings, should be provided for visitors, the number to be determined by the size of the room. The color scheme to be used in the room depends a great deal upon the exposure. It pays to use an enamel finish for walls, but flat finish is used in some hospitals and considered very satisfactory in every way. A French grey finish for light rooms is preferable, making a soft finish without any glare. For a dark room a light buff color is advisable. All blue tones should be kept well down, if used at all. In rugs plain reds, greens, or blues are good for the reason that they not only wear best but show stains and usage less than do figured designs.

Mahogany, considering everything, seems to be the best sort of wood finish for dressers, tables, etc., for use in private rooms. A mahogany piece of a high grade, while higher priced to begin with, is always cheaper in the long run. Not only is mahogany a good-looking wood, but if properly refinished it will be as good twenty years after its purchase as it was on the day it was bought. Mahogany, by the way, is always a harmonious finish, that goes especially well with brass beds. Furniture concerns making a specialty of catering to the needs of hospitals recommend that all furniture such as dressers, tables, and other pieces of cabinet work should be as free from mouldings, panels, etc., as possible, to enable them to be easily kept clean and dustless. Besides, such articles should have round corners and edges, making them agreeable to the touch, and tending to eliminate splinterings. Still further, it has been found that glass tops for these pieces give great satisfaction. In the use of such tops, the custom



A good type of bureau for hospital use.

has been to bring them out flush with the edges of all pieces rather than to inset them with a moulding, as is done in most hotel work. This is for the purpose of eliminating the joint between the moulding and the glass wherein it is possible for dust and moisture to settle. Smooth knobs for drawers are better than any other kind for a hospital, as they neither rattle, come loose easily, nor collect dirt. In buying dressers, it is the best plan to purchase nothing but dust-proof construction, which means that the dresser has panels between the drawers and on the bottom of the piece. Such construction practically eliminates dust collecting, as it is impossible for it to be sucked up from the floor and filtered through the various drawers as is the case when there is no dust-proof

protection. Casters are hardly necessary on dressers if care is taken to buy only those which are high enough from the floor, so that they can be easily swept under. The drawers of every dresser should be dove-tailed, front and back. When this construction is used each piece of the drawer-construction is fitted into the other piece with joints and glue so that dust does not come through, and also it is practically impossible for such construction to come apart.

Construction Important Point in Buying Chairs

In buying chairs, whether for private rooms or for dining rooms and sitting rooms, construction should be an important point if lasting service is expected. In general, box seat construction with bolted back posts and corner blocks in each corner under the seat is the ideal construction. Seats may be of plain wooden finish and can be used this way, or if desired a cushion may be tied to the back posts, which provides for extra comfort as well as sanitation.

Accepted practice in the modern, up-to-date hospital is for every private room to have a closet, with a special key, and a light to come on when the door opens. Such closets ought to be equipped with a rack and hangers such as the better hotels furnish. Having such closets does away with the necessity of having a wardrobe, which is usually top heavy, and, as a rule, cramped and unsightly. In this connection, wherever possible "fixed" pieces of furniture, where used at all, should be put right into the wall, thereby aiding the cause of cleanliness as well as saving space. Every room should be equipped with a private bath: there should be a total elimination of the wash pan and slop jar.

Smoking and lounging rooms for patients who are in an advanced period of convalescence are properly equipped with tables, following general specifications already given, also with wheel chairs, comfortable rockers, one or more couches—of metal construction previously described—having a raised head-piece, facilities for writing consisting of individual desks of the flat type, with perhaps one drawer, and some arm chairs which may be of wicker with room for pillows. Willow is especially fine for sun rooms and sitting rooms but experience has taught that despite its good looks it is short lived, and hence is not considered the most economical "buy" by any means. Besides, willow is not especially sanitary. Dust collects in the "pores" of the construction very quickly, and is difficult to get out. Some hospitals paint willow furniture frequently but this not only is a laborious and costly operation but also turns out badly in the majority of cases.

Sitting or waiting rooms are a necessary part of the well equipped hospital, and they can be furnished as elaborately as the hospital feels that it can afford. In this connection the fact should not be overlooked that such sitting or waiting rooms which are usually just off the main entrance-way, are, in a manner of speaking, the "face" of the hospital and can do much to inspire restfulness and confidence in the minds of visitors as well as advertising the character of the hospital, as reflected in its furnishings and the general service it renders. Leading hospitals have found it especially advisable to outfit at least one small, and conveniently located sitting room for the use of families who may visit the hospital in a crisis and want some place to consult together or rest while awaiting the result of an operation.

Upholstered Furniture Difficult to Buy

Upholstered furniture, which is used extensively in sitting and rest rooms, and in the main entrance-way of most hospitals of any size, is one of the hardest things in the furniture field to buy and know when you make your purchase that you are getting a piece of furniture that will retain its good looks and lasting quality. There is probably no article of furniture more beautiful than a handsome upholstered piece properly built, but there is nothing more unsightly or irritating than a bad piece of upholstery, especially of the "overstuffed" variety, which might furnish the utmost in comfort if properly constructed. For this reason, two general rules should be followed in buying upholstery. First, be sure that you are dealing with a house which has a reputation for turning out quality merchandise, and which is prepared to "stand back" of its upholstered goods—this is the best "buying rule" of all. Secondly, do not skimp on the price you pay for your overstuffed furniture. There are probably more "grades," as regards ultimate satisfaction, in upholstery furniture than there are freckles on a guinea egg, and one thing is sure, at least, you cannot get a good piece of upholstery from any house that will meet with your complete approval and satisfy you by its ability to stand usage, unless you are willing to pay a decent price for it. Therefore, it is unwise to go about looking for too much of a "bargain" in this line. In this connection, it is well to bear in mind the fact that repairing satisfactorily a piece of upholstery which was not properly constructed in the first place, is a near-impossibility. When it is fixed in one place, it yields in another, and you are continuously without the use of the article while it is in the repair shop. By mentioning these "pitfalls" there is no desire to give the inference that it is difficult to buy good upholstery. There is plenty of it made, and there are any number of houses which produce and sell it. At the same time, you should be warned against efforts to buy bargains at cut rates which within a few months turn out to be disappointments. In a word, the best is also the cheapest, in the long run.

In going about the purchase of a piece of upholstered goods, one of the best tests is to sit upon it. If it yields so that there seems no limit to its depths, and then springs lightly and quickly up again as you lift your weight it is probable that it is a pretty good piece of merchandise. Such action is the result of springs of high quality, wide webbing and good twine employed in the multiple tying of each spring. Probably the best stuffing material is long drawn hair, the next a mixture of hair and moss, and the next tow. The hair and moss combination usually stands up exceptionally well. In connection with testing the seat, it is wise to take into consideration, however, the use to which you will put the piece. If it is to be placed in a lobby where miscellaneous visitors will give it pretty constant use, do not buy a piece, the seat of which is too soft and springy. In the living room of a home such a seat would be desirable, but in a hospital waiting room or hotel a harder seat is desirable, so that the public cannot too quickly get it to sagging. Though many visitors will use the piece, hardly any of them will have to sit on it long, and therefore will not be inconvenienced if it is a bit hard.

For covering, plain brown or blue leather is recommended. There are leather substitutes obtainable which very closely match up with real leather and which give good service, the initial cost being less, too, however, it is doubtful if the general appearance and "feel" is up to that of real leather. But it is for the individual to decide whether it is worth while to make a monetary saving here at the possible sacrifice of a bit of style. As a matter of fact, tapestry coverings look and wear well, and are considered by many to be better all round than leather, though here again the individual taste must rule in making purchases. Tapestry comes in pleasing shades of

plain toned goods as well as in attractive figures, and as both are good taste there is nothing very difficult about selecting a good pattern. One thing in favor of tapestry is that when worn it can be easily and economically recovered. Leather and leather substitutes, however, are more easily cleaned.

Before leaving the subject of upholstered furniture, it might be just as well to mention one more general point as regards picking out a quality line. If the frame is exposed at any place, look it over carefully. If it appears to be of good lumber and well made, it may be assumed that the piece as a whole is well built, as no intelligent manufacturer will tolerate bad "frames" with a quality piece of upholstering. Incidentally, though a good many people think differently, it is not necessary to buy the so-called "custom made" upholstery in order to get quality. Many reputable manufacturers have so standardized the production of these goods that it is now possible to secure a high grade product at considerably less cost than when it is custom made.

A hospital dining room should conform to the general scheme of the rest of the hospital equipment. A dining table with a metal frame and a heavy glass top has proven satisfactory to a high degree. There is only one bad thing about such a table, that the glass is liable to get cracked unless proper care is taken. Several hospitals find it advisable to use a table with a sani-onyx glass top, and bentwood chairs which are comfortable as well as strong, light, and economical to buy. If a buffet for keeping silverware and linen properly stored, is purchased it should be without ornamentation, should have several roomy drawers, and should be of American walnut or mahogany finish. A mirror is hardly necessary and without it the buffet costs considerably less.

Hospitals being built today endeavor to set aside a space in each ward for a dressing and work room for nurses, which should be equipped pretty much the same as one of the large private rooms for patients, though possibly less elaborately.

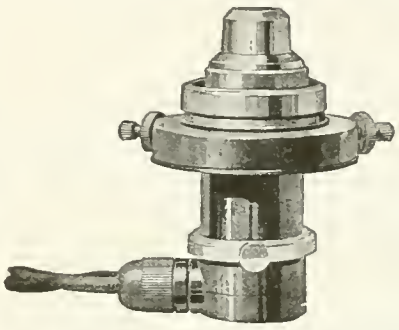
Unimportant as it may appear to be, any hospital executive will appreciate the fact that the manner in which the corridors of a hospital are furnished and kept up has a great deal to do with rendering first class service, as well as presenting a clean face to the public. Generally speaking, corridors should be as free from surplus furniture as possible. Some authorities hold that nurses' desks, consisting of a table with drawer or a couple of flat pigeon holes for writing material should rightfully be placed in the corridors just outside of the doorways to wards, and this furniture and possibly a few settees, plain wood finish, placed in suitable positions in corridors should constitute all of the furniture in these connecting passageways. Along all such "pathways" it is considered highly advisable to have rubber tile or linoleum laid, to do away with the clicking of heels disturbing patients. This tiling or linoleum should not cover the entire passageway or ward, but should be in strips on the places where the most walking is done. It has already been stated that rugs which can be taken up and cleaned at regular intervals are preferable for private rooms. If a carpet is used it should not have any border.

The entrance-way, or lobby, of a hospital can be made to play just as important a part in its success as in the case of a hotel, and therefore it is as necessary to have the proper furnishings here as elsewhere.

One of the largest and most modern hospitals in Chicago has its entrance-way equipped to resemble closely that of a hotel, with a big round "desk" facing the door and a roll top desk just inside the rail, at one side for the assistant superintendent. The superintendent has a private office, furnished like any business office, where he can consult with patients or relatives and friends. While it is not the purpose of this article to deal particularly with hospital methods, except as they are more or less directly concerned with the furnishing of a hospital, it may be mentioned here that the hospital just spoken of has former hotel clerks for its desk at the main entrance, and deems it of utmost importance that each visitor get immediate and courteous attention, as well as that records be kept at hand, in detail, for ready reference. The lobby of this same hospital is furnished with attractive rugs and upholstered chairs and settees to resemble the lobby of a hotel.

ILLUMINANT FOR DARK FIELD EXAMINATION

Until recently it has been difficult to secure proper illumination for dark field examinations. Accessory lamps were necessary, with results that have not always been satisfactory. A dark field illuminator which is made an integral part of the microscope has now been designed with the cooperation of Major J. B. Foster, Jr., and other officers of the Medical Corps of the Army Medical School.

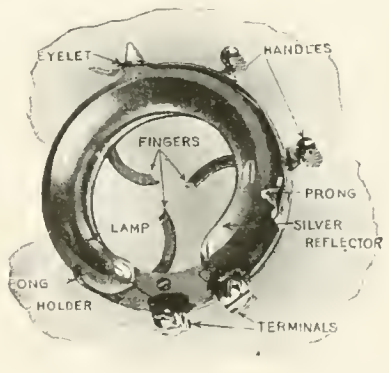


This illumination makes dark field examinations less difficult

The illuminant is a low voltage Mazda lamp, mounted in a telescoping sleeve, in such a way that it may be moved to and from the condensing lens in order to focus the light properly. By means of the smaller of two sets of centering screws, it may be centered to the optical axis; larger screws provide independent means for centering the lens system. The apparatus fits the substage ring of all the standard makes of microscopes. The necessary current for the lamp may be obtained on any lighting circuit using a suitable transformer for the alternating or direct current. Storage or dry batteries may also be used.

EXAMINATION OF OPAQUE OBJECTS MADE EASIER

The Silverman Illuminator, which is intended for use in the microscopic examination and photographing of opaque and semi-opaque objects, is the invention of Professor Alexander Silverman, head of the School of Chemistry of the University of Pittsburgh.



An illuminant which is always in place and adjusted because it is raised and lowered with the microscope.

This illuminator consists of a circular Mazda lamp, which surrounds the microscope objective, and furnishes a diffused and uniform illumination on the spot to be examined.

HONEY COMING INTO ITS OWN

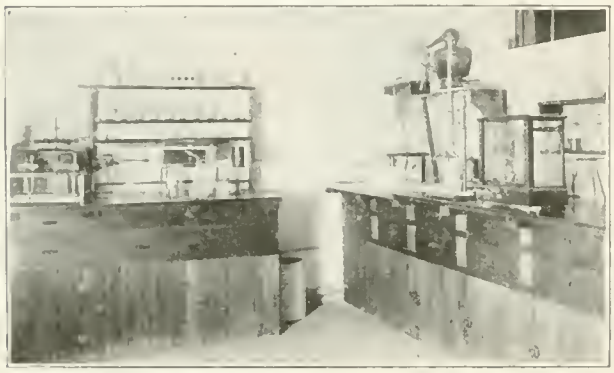
By GEORGE W. DIAL, Medina, O.

HONEY is more than something good on breakfast cakes, biscuits and waffles. It is something good in many forms and combinations, but especially it is something very good for both young and old.

Flowers you pick or gather have the greatest beauty. Foods familiar in their growth and preparation have an added attraction. The romantic details of bee-keeping, the life of bees, their production of honey, their association with sunshine, light and flowers, adds a distinctive flavor to the taste of honey.

Honey cook books list recipes by the hundreds for the use of honey in cooking and baking, drinks and desserts. The present day emphasis on the food value and health value of all foods adds an interest to the discussion of just what honey is and how it comes to our tables.

Due to post-war conditions in foreign countries and exchange rates the importation of foreign honey to the United States has been very heavy. The selling of these foreign honeys in our market has emphasized for the consuming public the difference in quality between the various kinds. Something over two hundred honeys have been chemically analyzed as to their contents, even to the minutest particles of Nature's coloring and flavoring contributions.



Laboratory for testing honey as to grade, purity and flavor.

Each flower secretes a nectar that provides a honey distinct in color, flavor and consistency. So far as the supply of the flower permits, the busy bee gathers the nectar from one variety exclusively. He does not like mixed drinks and travels many an extra mile to satisfy his taste for an unmixed flavor.

When the children brought word home from school that one pound of honey represented a total winged flight by bees equal to the distance twice around the world, quite a few parents doubted the word. But scientists and naturalists have by experimental tests, proved this statement.

Honey, especially honey in the comb, does come in rather direct "bee line," from the flower to your table. The flower nectar is deposited in the wax comb cells in the hive, and the water is evaporated from it by the high temperature of the hive and the constant ventilation maintained by the wings of bees stationed about the entrance and on the inside. Chemical changes producing honey from the flower nectar result from the original acids in the nectar and from acid added by the bee and to some extent by the wax.

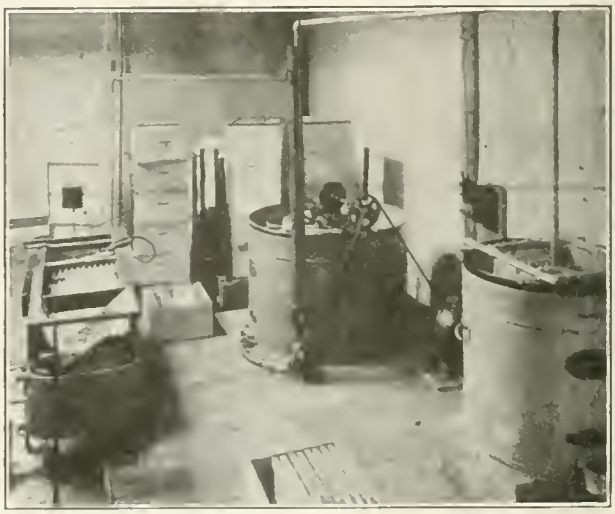
From the hive, comb honey in a wood section comes direct and untouched to the table except for one stop when the section is placed in a wax paper and sealed carton container. Cartons in cases, and shipping cases in specially designed shipping "carriers" insure comb honey against breakage and leakage in transportation.

Liquid honey, commonly known as "extracted honey" because it is liquid honey thrown out of combs by a machine using centrifugal force, also comes to your table unchanged and untouched by human hands. Liquid honey is not honey strained from "mashed-up" honey combs.

Extracted honey is stored in the hive in large honey combs, equal in size to about ten one pound sections. These large combs are made especially for the extracting machines which throw the honey out of the cells. After the cell caps or tops are removed, the honey from the extractor goes through glass lined pipes, to glass tanks, through which it is drawn to automatic bottling, capping and labeling machines.

Each flower produces its own distinctive honey, with its own peculiar flavor and with a color that may be almost any shade of the rainbow. It is this fact that makes differences in the quality and in the price of the honeys offered by food packers. From the tropical countries with their luxuriant flowers strong in color and in scent, we get strong honeys that are not to be compared to our delicate honey flavors known as white clover, basswood, sweet clover, sage and orange. There are certain flowers, it may be noted, though they are very few in number, which produce honeys that are not palatable. The poison honeys contrary to reports are practically unknown. Many of the honeys which are not palatable or are not chosen for table use are used for medicinal purposes and in baking.

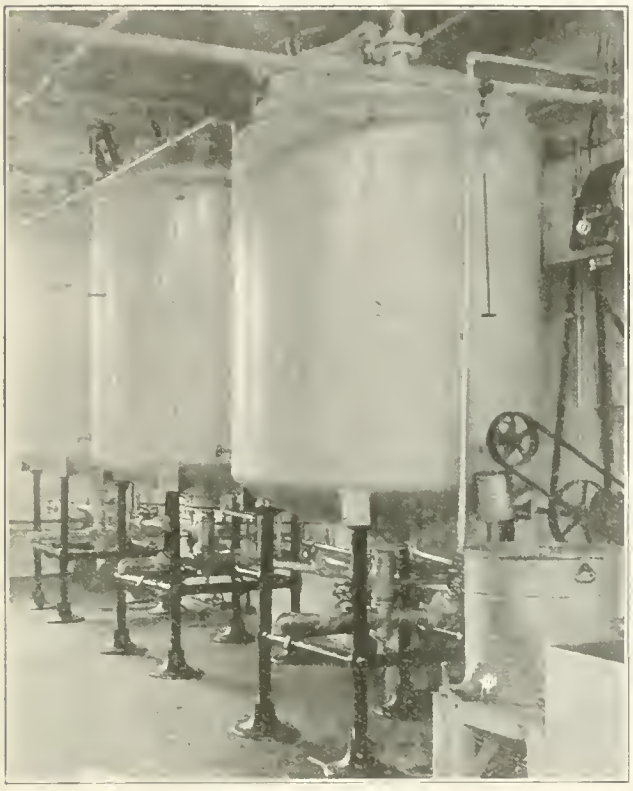
It will doubtless surprise a great many to learn that the secret of their special brand of tooth paste lies in the fact that a component of this paste is honey. Manufacturers of the best brands of candies use very large quantities of honey, not alone for its flavor and sweetening quality but particularly because of the keeping quality which it adds. No other substitute has been found for



Power "extractor" for extracting honey from the uncapped cells. The uncapping table is shown at the left.

honey in this respect, and it is because of this quality that large manufacturers and packers purchase honey in carload lots.

The use of honey by the bakers of fancy baked goods,



Honey blending tanks, holding three tons each.

if it has not been guarded as a secret has never been publicly advertised. If such public announcements had been made it is very likely that the consumption of honey in the home in baking and cooking would be many times what it has been, however, it is growing at a fast pace both for table and kitchen use.

Some food authorities recommend the daily use of honey. These authorities have followed up investigations with the result that they make the following statements:

"An examination of the chart will show that the bread with honey was digested and left the stomach as quickly as the bread alone, although the addition of the honey had practically doubled the food value of the product from the energy standpoint.

"The use of honey with bread and in similar ways would therefore appear to be generally preferable in the case of children to the eating of candies. Honey serves to make the highly nutritious bread more palatable, leading to a greater consumption of body-building foods, instead of depressing the appetite as is likely to be the case with candies which are eaten between meals. At the same time honey furnishes to the body very considerable amounts of energy in the most available form. The high place given to it in the diet is therefore well deserved."[1]

Honey is very helpful to the digestion of both old and young. In Biblical days honey was not considered a delicacy, and it was not used in place of sugar (for at that time there was no sugar to be replaced), but it was used because of its value as a food for good health. It was therefore always classed with milk.

Due to the limited production of honey and because of the increased production of cheaper sweets people until recently did not consume the quantities of honey which they are now demanding. The food value of honey and the serious effects of a too generous consumption of devitalized and manufactured sweets, are better realized today.

The production of honey during the past ten years has more than doubled and there is honey enough for all, honey of the best and the finest grades, at very fair prices, prices that are really cheap when food values of honey are compared with the values in other foods.

1. Dr. Philip B. Hawk, Jefferson Medical College, Philadelphia, Pa.

NEWS ITEMS FOR DIETITIANS

Miss Florence West has returned to Henrotin Hospital, Chicago. During her absence, Miss Phoebe Mentzer was dietitian at this hospital.

Miss Gertrude Oehning, formerly at Evanston City Hospital, has accepted a position as dietitian at Stuart Circle Hospital, Richmond, Va.

Miss Margaret Hoffman resigned her position at Ohio Valley General Hospital to enter Illinois State University. After a year of postgraduate work at this University, Miss Hoffman will take up the study of medicine. Miss Eleanor Muth succeeds Miss Hoffman at Ohio Valley General Hospital.

Miss Louise Keegan is dietitian at the Montefiore Home, New York. Miss Keegan accepted a position at the Meriden Hospital, Meriden, Conn.; after being there only three weeks, she was asked to take charge of the dietary department at Montefiore and the Meriden Hospital very kindly released her.

A diabetic clinic has recently been established in Vancouver by Miss Esther Kinney. Miss Kinney was for several years dietitian at Vancouver General Hospital, but was compelled to give up the more strenuous work because of poor health. The physicians of the city, and particularly those who are associated with the hospital in which Miss Kinney was dietitian, are welcoming this clinic. Dietitians all over the country will be glad to follow its developments, as it is a movement in which we are all interested.

Does not this schedule of meetings in Boston sound interesting? We greatly regret we did not have a report of each meeting at the time it was held.

REPORT OF THE MEETINGS OF THE DIETITIANS IN BOSTON, 1920-1921. SUBMITTED BY OCTAVIA HALL, DIETITIAN, PETER BENT BRIGHAM HOSPITAL.

November meeting held at Boston City Hospital. Speaker, Miss Josephine Thurlow, Superintendent, Cambridge Hospital, "Teaching Dietetics to Nurses in Reference to State Board Examinations."

December meeting held at Boston Dispensary. Speaker, Miss Bertha Wood. "The Food Clinic at the Boston Dispensary."

January meeting held at Massachusetts General Hospital. Speaker, State Institutional Buyer, "Buying Cooperatively for Thirteen State Institutions." Speaker, Mr. Arthur L. Boynton of Morandi-Proctor Company, "Modern Equipment for the Institutional Kitchen."

February meeting held at Parker Hill Public Health Hospital. Speaker, Captain Brown, "The Field Open for Dietitians in Public Health Hospitals."

March meeting held at Corey Hill Hospital. Speaker, Dr. Joel Goldthwaite, "Diet in Reference to Posture."

April meeting held at Mt. Aarat Restaurant. 6 o'clock dinner—only foreign food served. Miss Bertha Wood explained the cooking of this food.

May meeting held at Peter Bent Brigham Hospital. Speaker, Dr. Cyrus C. Sturgis, "Method of Doing Metabolism." "Diets that are used as a result of Metabolic Experiments."

Election of Officers for 1921-1922.

June meeting held at Waltham Training School. All brought supper for an enjoyable picnic.

Officers 1920-1921—Chairman, Octavia I. Hall, Peter Bent Brigham Hospital; Secretary and Treasurer, Margaret Anderson, Cambridge Hospital.

Officers 1921-1922—Chairman, Bertha Wood, Boston Dispensary; Secretary and Treasurer—Elizabeth Tyler, Parker Hill Public Health Hospital.

Meetings, Conventions and Conferences

ALBERTA HOSPITAL ASSOCIATION TO DISCUSS INTERESTING TOPICS

By mutual arrangement of the executive committee of the Alberta Hospital Association and Alberta Association for Registered Nurses it was decided to hold the conjoint annual convention of the two associations at the New Medical Building, University of Alberta, on November 8, 9, 10 and 11, 1921.

It is expected that the meeting will again be of mutual aid and benefit. The convention offers an excellent opportunity to further the chief objects in which the members of the two associations are interested.

It has been proposed that the convention discuss by what means nurses might be equipped as technicians to make elementary laboratory analyses, and to operate x-ray apparatus to meet the demand for these facilities in rural hospitals. It is hoped to arrange a demonstration in laboratory training for nurses, and a report will be given by the committee in charge of the undergraduate nurses' training section on the feasibility of giving all nurses in training a short period at the University.

A memorandum will be presented to the convention suggesting a scheme for affiliation of training schools with general hospitals.

It has been requested that the convention discuss standardization of training pertaining to dietetics for infants, with particular reference to the employment of nurses in the provincial public health and child welfare services. Miss Brown, of Regina, who is recognized as an authority on training, will speak at the convention.

It is proposed to arrange a section of the program dealing particularly with hospital management and finance which will be of particular interest to civilian members of hospital boards and superintendents.

MANITOBA HOSPITAL ASSOCIATION MEETS IN WINNIPEG

The Annual Meeting of the Manitoba Hospital Association will be held at the Medical College of the Manitoba University, Winnipeg, on Monday and Tuesday, November 7 and 8, 1921.

This date has been selected in order to fit in with the annual meeting of the Manitoba Medical Association and thus secure a larger attendance.

The program will consist of short papers on matters of live interest to hospitals, both large and small. Two periods are also being arranged for round table discussion of hospital problems.

Members should be thinking over the problems upon which they desire information. Bring your questions with you, or what is more preferable, mail them to the secretary, so that time may be given to prepare proper replies.

There is a wide field for the Manitoba Hospital Association in a rapidly growing Province such as our own. Such Associations have proved very helpful elsewhere.

While primarily designed for hospital trustees and executives, it is desired that everyone interested in hospital work should attend.

The tentative program is as follows:

Monday, November 7, 1921

9:30 A.M. Registration.

10:00 A.M. Address of Welcome.
Convention open.
Appointment of Committee on Resolutions.
Address: "The Modern Hospital and Its Community Relations."
George Stephens, M.D., Superintendent, Winnipeg General Hospital.
"The Professional Work in the Hospital—Minimum Standard—Why Records Are Required."
By James McKenty, M.D., Chief Surgeon, St. Boniface Hospital.

1:00 P.M. Buffet Lunch at the Winnipeg General Hospital.
Inspection of Hospital.

2:00 P.M. Financing the Hospital. The Provincial Act As It Effects the Hospital.
"Hospital Accounting and Purchasing."
By George Stoker, Municipal Hospitals.

8:00 P.M. Round Table Discussion of Hospital Problems.

Tuesday, November 8, 1921

9:30 A.M. "The Minimum of Training, Education, Equipment for Hospitals Conducting a Training School for Nurses."
By Miss K. A. Cotter, Superintendent, Dauphin Hospital.
"Affiliation from the View Point of the Larger and Smaller Hospitals."
By Miss M. C. McNeel, Superintendent, Children's Hospital.
"The Manitoba Central Nurses' Directory."
By Miss Elizabeth Carruthers, Registrar.
"The Manitoba Association of Graduate Nurses' Act and Proposed Amendments."
By Miss E. Gilroy.

12:30 P.M. Visit to Municipal Hospitals, where lunch will be served.

2:00 P.M. Annual Business Meeting and Election of Officers.

3:00 P.M. Round Table Discussion of Hospital and Nursing Problems.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR.

Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York

DISPENSARY NEEDS OF A SMALL CITY*

BY S. G. DAVIDSON, SUPERINTENDENT, ROCKFORD HOSPITAL, ROCKFORD, ILL.

Mr. Davidson gives a recipe on "How to Found a Dispensary in a Small City." Probably it would also be applicable to a large city, but it has been tried successfully in Rockford with 70,000 inhabitants. Mr. Davidson first made a survey of the other institutions of the city and found no dispensary in operation. A meeting was then held with the other three active associations of the community who enthusiastically endorsed the proposition, and agreed to help in making a survey of the need. The need was found to be very real. Newspaper publicity was then secured, rooms fitted for temporary use and the first clinic was held. It was a great success and led to the immediate demand for numerous other clinics on special services, which were established as soon as the need was proven. Pay clinics have not been started, for the hospital feels that this dispensary movement, being largely educational, must go slowly if it is to grow surely.

ALL hospital people are interested in the establishment and operation of dispensaries. They are interested because dispensaries are such a vital part of hospital service, not only for the work they furnish the staff or the clinical material they may bring into the hospital wards, but because of the great good they accomplish in improving the health, correcting the physical defects, and aiding the needy of the community.

Through its dispensary, the hospital is enabled to give aid to a far greater number of people needing such help, and at far less cost, than any other agency in corrective medical practice. In the light of all that has been written on this very important subject, there is little need, at this time, to go into a discussion of this phase of dispensaries.

Must Be Founded on Definite Knowledge

Those who feel as strongly on the subject as I do will realize that a goodly part of the hospital is missing, if a dispensary is not operated in conjunction with the institution. I believe that, in a general way, we all know or feel that there is a distinct need of a dispensary in our community, or that such a service should be a part of our hospital, that there is work for it to do, that there are people needing such service, and in our thoughtful consideration of our institution, we dream or plan such a service. However, we cannot stop with the idea or the plan, because if we do, years will roll by and the need will not be filled; or, if we go to our staff and board of trustees with the general statement that we think a dispensary is needed and that it would be a good thing for the hospital, and if we make such assertions without being pretty thoroughly conversant with every detail and factor which may enter into the establishment and operation of such a dispensary or without being sufficiently posted to meet every argument which may be raised against it in any discussion of the project, we will never have our dispensary, or if it should happen to be installed on the spur of the moment, it will never be a real success.

The establishment of a dispensary must be founded on very definite knowledge of conditions, needs, and methods of meeting them. Within the past three or four months, I have had the opportunity and pleasure of establishing a dispensary in connection with one of three hospitals in a city of 70,000 inhabitants, situated 100 miles from Chicago, the hospital having 110 beds and drawing its patients from a number of smaller communities within a radius of twenty-five or thirty miles. And the story of what was done and what has been accomplished thus far may be of more practical interest and value to you than any theoretical discussion of dispensaries, their establishment and operation.

In this city, which is a large manufacturing center, there is a working population composed largely of Swedish and Italian peoples, a small percentage of other nationalities, together with the American. The first item of interest in regard to health conditions was the absence of any dispensaries or of any health conservation activities on the part of the city government. There was, however, a state clinic being conducted once each month, more especially for orthopedic cases. As is well known, there is a very distinct sentiment among physicians against state medicine, and as the state health department sent their own doctor from Springfield to examine these cases, some of which were being sent to Springfield for operation, the local men were quite opposed to clinics and this is a condition, or rather a factor, which must be given a great deal of consideration. What is the best manner of overcoming opposition, on the part of the medical profession, in the establishment of outpatient work in small communities? For we have to bear in mind that these doctors are giving a great deal of their time in caring for the poor in their homes. The doctors care for these families when some of the mem-

*Read at the Twenty-Third Annual Convention of the American Hospital Association, West Baden, Ind., Sept. 12-16, 1921.

bers are working and they are paid for their services, and then they are perfectly willing, so they say, to go on caring for the families when the members are not working.

Our next step was to secure information, relative to the mortality rate, and this information was very meager. The baby death rate for 1920 was 80.4 per one thousand births, while the total death rate was 11.76 per one thousand population, both of which were very low, due undoubtedly to good living conditions and to high wages during the war period.

Found Local Need

There are, however, several very active associations, the visiting nurses, the public welfare, the anti-tuberculosis society, and in addition to these, school nursing is being carried on in a manner superior to the average community. After gathering together as much information as possible, I had a long talk with one of our staff members, a leading pediatrician, who also has charge of the school children inspection work. From his knowledge of conditions, among the school children, he felt there was distinct need of dispensary work for babies and children, more especially as there had existed, since January first, a local condition of about 50 per cent unemployment. He felt that many families were beginning to feel the pinch of hard times, that they would not be able to purchase the usual nourishing food, and with the hot summer coming on, a great deal of sickness would exist among babies and undernourishment among the children. We asked for a meeting of the representatives of the three organizations previously mentioned, for the purpose of getting their opinions. In the meantime, we looked over our hospital and found on the ground floor in the older part of the building two rooms, one a corner room, nine by twelve feet, which was occupied by a maid, and next to this a room, twelve by twenty-four. The larger room was being used to store bedding, etc., and was also used as a sewing room. It took only a short time to find a place in the basement for the bedding and also a good sewing room, so we went into the meeting with the knowledge we had the necessary space. The general sentiment at this meeting was unanimous in supporting the opinion of the staff doctor; but it was decided to have a survey made by the nurses of the various organizations to determine whether or not our conclusions were correct. This survey covered every poorer section of the city, and when the reports were turned in, we discovered that conditions were not so acute as we had thought; that men, out of work, were getting odd jobs; that they were drawing on reserve funds; that their gardens were helping them out for the summer; and that there was, as yet, comparatively little undernourishment among children. But we also discovered that families, in their effort to practice economy, were cutting down first on their milk supply. We felt that this would have a serious effect on the health of the children, so it was arranged to buy milk at a very low cost and sell it at the various playgrounds at two cents per pint, and a fund was made available for this purpose. It was, however, brought out very definitely at this second meeting, that families without income would, undoubtedly, be in need of medical service for which they would have no funds.

Hold First Children's Clinic

This meeting, then, developed the fact that there was a real need of an out-patient department for sick babies and children, and that there would probably be found among those children to whom milk would be sold at the play centers, a few so undernourished as to need the advice of a physician. We, therefore, arranged to hold our first out-patient clinic for children on Monday, June 20. We secured good newspaper publicity, and on that first morning, seventeen children, ranging in age from nine months to fourteen years, were brought in for examination. Of these, twelve were referred by the Visiting Nurse Association and five came of their own accord. Upon examination, we found four to be surgical cases; two, mental; one, eye; and the remainder, feeding cases, three of which were children nine to thirteen, plainly undernourished. Of these seventeen cases, four were transferred to the hospital. At this point, I think it would be of interest to say that we had given careful thought to the out-patient records and had printed a form which we felt would meet every need. We only had fifty made up on the proof sheet and used these at the first clinic in order to discover where we might improve on them. They were made up, too, to fit in with our hospital records.

Our examination room was furnished with all the equipment used in our old emergency examination room and has since been used as an emergency room also. The waiting room was furnished with discarded school room benches. The hospital had never had a children's department, our pupil nurses receiving their children's training in one of the large Chicago hospitals, but late in May we severed our affiliation and recalled our pupil nurses in order to give them their children's training under our own supervision. We had foreseen the need of such a department and had purchased six five-foot children's beds and eight four-foot cribs. On the second floor of the old part of the hospital there was a four-bed ward at the end of the corridor, while outside was a covered porch. We had the porch inclosed with wire screen at a cost of $38.00 and, with the ward, had room for fourteen children. To this porch ward went the four feeding cases, two clubfoot cases, one congenital hip case, one poliomyelitis case, and one tuberculous spine.

Physicians Start Record Keeping

You may be sure this was a red letter day at this hospital, for it was also the beginning of record keeping on the part of the physicians, and the opening of a fully equipped laboratory in charge of a Class A pathologist, and our doctors were considerably keyed up. Every staff man who came in had to go back and see the laboratory and out-patient department. While the pediatrician and myself had discussed the operation of the children's clinic in detail and while we had talked casually of the out-patient department to the other staff men, they had not taken very much interest in the matter, feeling that it was a nice thing to consider theoretically, but they never seriously considered the starting of such service. However, every one of them came out of that out-patient department smiling happily, shaking their heads and forming into groups to discuss this wonderful miracle which had grown up overnight, its value and its success. Then they came around hunting for the superintendent, demanding that various other clinics be started at once, for all the various services. To each we stated that as soon as the need was demonstrated, we would furnish a schedule, but that they were in a far better position to determine this need than the hospital. A special meeting of the staff was called, which was fully attended, and the need of a complete out-patient department was thoroughly discussed. Every man told of the things he knew which demonstrated the need of such a service, and it was unanimously agreed that we should inaugurate such

a service as soon as it could be arranged. A committee was appointed to confer with and assist the superintendent. The next morning was the second of our children's clinics, and twenty-one new cases were in attendance. And in addition, six returned from the week previous. We had a regular overflow meeting, our dietitian taking care of the feeding and undernourished cases and receiving advice from the attending physician, who, with his assistant, was literally swamped in the one small examination room.

One thing we had to do promptly was to set days for such other clinics, as we found cases which needed to be referred to the various services. We arbitrarily did this, telling the mothers to return to the surgical; the ear, nose and throat; the eye; the mental clinics, etc., on the day we then determined upon. After the clinic, the chief came to the superintendent and demanded more examination rooms. He was emphatic in his statement that another examination room must be had, at once. Then we sat down and made up examination cards for each service and assigned our staff to begin the first week in July. We then purchased sufficient beaver board and put in a partition of this material with a door dividing the large waiting room in half and making one portion another examining room.

Papers Give Clinics Publicity

On the following Saturday, the three dailies carried large headline stories about the various clinics, including the time, etc. On Monday, we started with the following schedule: 9 a. m., sick children, and at the same hour, nutrition clinics; 11 a. m., psychopathic; Tuesday, 9 a. m., eye, and at the same hour, prenatal clinics; Wednesday, 9 a. m., medical; Thursday, 9 a. m., ear, nose and throat; Friday, 9 a. m., surgical; Tuesday evening, 7 p. m., venereal.

Our staff was organized so that each man had his part. Where there were two men on a service, one was assigned out-patient department and one house for six months and then switched for the following six months.

The three local welfare organizations have cooperated splendidly. The Public Welfare Association investigates every case, as to its social condition. The visiting nurses and the Red Cross refer many cases. The visiting nurses also take one of our pupils into the follow-up service. Our laboratory and drug room are at the disposal of the clinics at all times. Minimum charges are made whenever possible.

While it has been our endeavor to make it clear that only the very poor are to receive the benefits of the out-patient department, there have, of course, been a number of cases attending the various clinics who were financially able to pay their family physician for examination and treatment. Sometimes this can be noted from the general dress and appearance of the patient or the relatives accompanying the patient, and sometimes the information is given quite frankly to the admitting clerk (and in these cases it is simply a misunderstanding on the part of the prospective patient as to what the department has been established for). In our community, as in most others, there is a lack of understanding, sympathy, or cooperation among various groups of practitioners, and those men, connected with other hospitals, deeply resented the fact that some of their patients were coming to our out-patient department and receiving advice and, where needed, treatment. We have tried to minimize these cases as follows: when the patients enter they are asked the following questions: name of father, name of mother, by whom employed, income, number in family, number of sick members of the family, and name of family physician. If this information indicates that the family may be in a position to pay for their services, a few words of advice regarding the patient is given and he is then referred back to his family physician with a note from the attending clinical man as to what he may have discovered or may have said.

All other cases are given a thorough examination, treatments are ordered and the patient is asked to return on the next clinic day. If it is a first visit, the name, address, and information given are transcribed on a sheet which includes numerous other questions dealing with the social or financial condition of the family, and these are sent to the local public welfare organization, who make the entire investigation for the hospital and send the reports back in order that we may have them at the next visit of the patient, or that we may know what course to pursue if the patient has had to come into the hospital immediately. In this manner we are minimizing the amount of care given to people in a position to pay and it has done much to eliminate the criticism from the family physicians or from other groups of men. That too much consideration should not be given to these criticisms is evidenced by the fact (and it has been our pleasure to point out to some of our critics specific cases) that patients come to us who have been under the care of some other physician at some previous time and we find the patient in a serious condition or needing immediate medical relief so that we are able to say, "If this is the kind of service you have been giving your patient you ought not to say very much about it because it reflects upon your practice of medicine."

In the follow-up of these cases we are using one of our pupil nurses in conjunction with the Visiting Nurses' Association.

Have Not Started Pay Clinics

We have not attempted to form any pay clinics, nor do I think we will for the present. We are keeping very clearly in mind the fact that in a small community such as ours, new ventures like this are largely educational, and that, if they are to ever grow into the big things they ought to be they must develop slowly. Also in order to secure the best results the demand for improvement in the operation of the idea must come from the outside. In this connection, I wish to emphasize the fact that we all in our hospital realize that there are many imperfections in the way in which we are operating this department and that there are many improvements to be made. We realize that the waiting room is very imperfect, that the examination rooms are not equipped as they should be, that they are crowded, that there should be pay clinics, that there should be better follow-up service, that the work might be more thoroughly done, but I am strongly of the opinion that no person or group of persons can get the vision of a big idea, a big plan, or a big development and sit down and plan the operation of this idea or development in detail, then put in all the machinery, start it off, and have it work out as planned. But I do believe most thoroughly that we ought to take our idea or our development plan, put it into operation as quickly and as well as possible, and then iron out the wrinkles afterward, and improve it as we go along. I believe that the service this little out-patient department has rendered the community during its three months of operation, the good it has accomplished, and I might add the lives that have been saved, fully justifies its existence and far outweighs its many small imperfections.

It may be of interest to you to know that in addition

to the people from the city who have attended the clinics, we have had a considerable number of patients from the rural communities; farmers and residents from small towns are coming in here or being brought here by the rural physicians.

So Far Little or No Expense Incurred

You will observe that there has been little or no expense attached to our out-patient department thus far, but with the continued growth of the work the matter of financing it must be given consideration. As we develop our other hospital facilities, it will be necessary to use the present rooms for other purposes and in doing that we find ourselves in the fortunate position of having a building on the grounds facing a side street, in which are housed our maids and porters. The ground floor of this building could be made into a really first class out-patient department, but when this is done there will be additional costs in higher wages to the help and in maintaining the building. And in addition to this, as our hospital fills up with patients, there will be the additional cost in maintaining the increased amount of charity work which is now taken care of with our present overhead, with no additional expense. The method we are most seriously considering is that of either going before the public with a statement of exactly what our free children's department and our out-patient department are costing us, and asking for contributions to support this work, or on the other hand putting this part of our hospital service into the federated charities. We feel that support of such special work will be far more generous and spontaneous than if we should ask the public to support the hospital as a whole.

NATIONAL BOARD PLANS TO GIVE CERTIFICATE BY EXAMINATION

The National Board of Medical Examiners has just completed its first five years' work and with it the trial period of its usefulness. The principle which this board has stood for, namely, the establishment of a thorough test of fitness to practice medicine which might safely be accepted throughout this country and abroad, has been widely accepted. Since the board was organized by Dr. W. L. Rodman, in 1915, eleven examinations have been held. These examinations have been conducted on the plan of holding at one sitting, a written, practical and clinical test for candidates with certain qualifications, namely a four-year high school course, two years of college work, including one year of physics, chemistry, and biology, graduation from a Class A medical school, and one year's internship in an acceptable hospital. These examinations have covered all the subjects of the medical school curriculum and have been conducted by members of the board, with members of the profession resident in the place of examination appointed to help them. Such examinations have been held in Washington, Philadelphia, New York City, Boston, Chicago, St. Louis, Rochester (Minn.) and Minneapolis. During the war a combined examination was held at Fort Oglethorpe and Fort Riley. There have been 325 candidates examined, of whom 269 have passed and been granted certificates.

Starting with the endorsement of the Council on Medical Education of the American Medical Association, American Medical College Association, and various sectional medical societies, the recognition of the Army, Navy, and Public Health Service Medical Corps of the United States, and certain state boards of medical examiners, the certificate is now recognized. Also by twenty states, as follows: Alabama, Arizona, Colorado, Delaware, Florida, Georgia, Idaho, Iowa, Kentucky, Maryland, Minnesota, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Pennsylvania, Rhode Island, Vermont and Virginia, the Conjoint Board of England, the Triple Qualification Board of Scotland, the American College of Surgeons and the Mayo Foundation of the University of Minnesota.

Widespread Demand for Examination

There has been such a widespread demand for an opportunity to secure this certificate by examination, that the board has now adopted and will put into effect at once, the following plan: Part I, to consist of a written examination in the six fundamental medical sciences: anatomy, including histology and embryology; physiology; physiological chemistry; general pathology; bacteriology; materia medica and pharmacology. Part II, to consist of a written examination in the four following subjects: medicine, including pediatrics, neuropsychiatry, and therapeutics; surgery, including applied anatomy, surgical pathology and surgical specialties; obstetrics and gynecology; public health, including hygiene and medical jurisprudence. Part III, to consist of a practical examination in each of the following subjects: clinical medicine, including medical pathology, applied physiology, clinical chemistry, clinical microscopy and dermatology; clinical surgery, including applied anatomy, surgical pathology, operative surgery, and the surgical specialties of the diseases of the eye, ear, nose and throat; obstetrics and gynecology; public health, including sanitary bacteriology and the communicable diseases.

Both Written and Practical Examinations

Parts I and II will be conducted as written examinations in Class A medical schools, and Part III will be entirely practical and clinical. In order to facilitate the carrying out of Part III, subsidiary boards will be appointed in the following cities: Boston, New York, Philadelphia, Minneapolis, Iowa City, San Francisco, Denver, New Orleans, Baltimore, Galveston, Cleveland, St. Louis, Chicago, Washington, D. C., and Nashville, and these boards will function under the direction of the national board. The fee of $25.00 for the first part, $25.00 for the second part, and $50.00 for the third part will be charged. In order to help the board, the Carnegie Foundation has appropriated $100,000 over a period of five years.

At the annual meeting held June 13 of this year, in Boston, the following officers were elected: M. W. Ireland, Surgeon General, president; J. S. Rodman, M.D., secretary-treasurer; E. S. Elwood, managing director.

Mr. Elwood will personally visit all Class A schools during the college year to further explain the examination, etc., to those interested. Further information may be had from the Secretary-Treasurer, Medical Arts Building, Philadelphia.

PATIENTS FOLLOW WORLD SERIES

The patients of Roosevelt Hospital, New York City, were well informed of the progress of the recent world series games between the Giants and Yankees by a novel method. The bell system used to summon doctors and nurses from one part of the hospital to another was utilized for inning-by-inning reports. George W. Stock, superintendent of the hospital, devised the code, which was explained to the patients beforehand. To those patients especially interested in the series, more detailed reports were given by the nurses. Two hundred keenly interested fans followed the game in this manner.

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OCCUPATIONAL THERAPY AND REHABILITATION

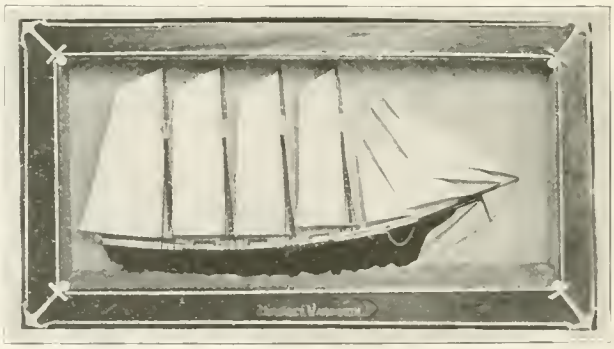
Conducted by HERBERT J. HALL, M.D., President, National Society for the Promotion of Occupational Therapy, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

OCCUPATIONAL THERAPY AT KENILWORTH HOSPITAL*

BY BERTHA THOMPSON, HEAD RE-AIDE, UNITED STATES PUBLIC HEALTH SERVICE HOSPITAL NO. 45, BILTMORE, N. C.

THE hospital with which I am connected, the United States Public Health Service Hospital in Biltmore, N. C., is not a very large one. We have had between 250 and 300 patients most of the time since it opened last November. Many of our patients come in for examination only, and remain at most for a week or two. Others stay several months. We have three surgical wards, five wards for general medical cases, two of which are for colored patients, and two wards for tuberculosis. Some mental cases come in, but these are eventually transferred for treatment to other hospitals.

The hospital building is the large hotel known as Kenilworth Inn, which has been rented by the government. It was used as a military hospital for a year and a half. It is beautifully situated on a hill overlooking the well known Vanderbilt estate. Some ten or twelve private houses nearby have been rented for the doctors and their families, and for nurses' and aides' quarters. There is also a recreation house on the grounds, built by the Young Men's Christian Association while Kenilworth was an army hospital, and we have our workrooms at present in this attractive building.



1. Schooner model in high relief. One of many made from scraps of old lumber by a tuberculous patient at Kenilworth Hospital, U.S.P.H.S. Such good work as this should command a fair price and might easily become a vocation as ship models are very much in demand.

The first space assigned to me for the work was a corner of the large ballroom in the main building. This room was used for recreational purposes also. We carried on our work there under great difficulties for five months, until the coming of warm weather made it possible to take possession of a group of rooms in the recreation house, consisting of an office, a room for basketry and weaving, another for leather work and bookbinding, a good sized storeroom, and two very small rooms, one of which is used for painting and staining, but will later be equipped for dyeing. None of these rooms are large, but they have served very well so far. In the main building we have a wood shop, and a room where we keep supplies for the ward work.

All but a small proportion of the supplies used previous to August first, were purchased by the Red Cross. It is due to the very generous support of this organization that we were able to accomplish so much in the first seven months of our work. As nearly as I could estimate from the incomplete records available, between the middle of December and the first of August about $150 was spent for tools and equipment, and $1,400 for materials. We have returned to the Red Cross $575 received from the patients for materials they have used and paid for. We still have some Red Cross supplies on hand, but since August first considerable government material has come through to us.

This brief survey will give you some idea of the size of our department.

The Bureau of Public Health Service was asked to undertake an almost overwhelming task when called upon to provide for the hospital care and treatment of the War Risk Insurance patients. And as far as occupational therapy was concerned, it soon became apparent to me that there would be considerable delay in making adequate provision for necessary supplies and equipment. Therefore, wishing to make the Red Cross funds go as far as possible in buying materials, I decided to begin with a few of the crafts that required the least expensive tools and equipment, leaving such others as jewelry, metal work, carpentry, large loom weaving, etc., to be provided for by the Public Health Bureau as soon as possible. The result has been that up to this time our work has been confined to basketry, leather work, modeling, toy making, bead work, knitting, crocheting, knotted string work, some simple weaving on bedside looms, and such bookbinding as could be done without much equipment. A wood shop was soon needed in order to have some place in which to make bead looms, frames for weaving,

*Read at the September, 1920, meeting of the National Society for the Promotion of Occupational Therapy.

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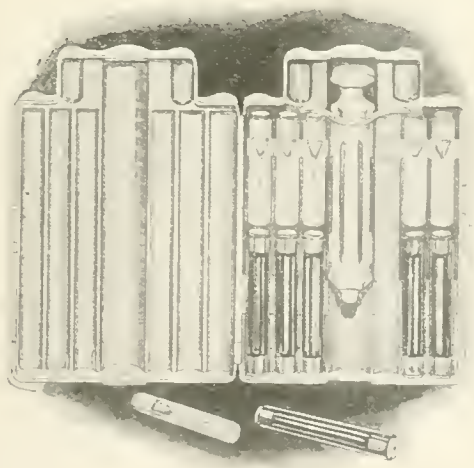

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etc., so I bought a few carpenter's tools, trusting that the Bureau would complete the equipment later. In spite of the limited supply of lumber we could obtain, and the few tools available, the patients have done some good work in the shop. In addition to bead looms and frames for weaving, they have made toys, bird houses, cribbage boards, book ends, walking sticks, kites, flower boxes for the hospital, and cases for writing paper. Any number of frames for reed lamps, and wooden bases for trays, have been prepared in the shop.

Basketry Most Popular

I was able to bring only a small exhibit of the work of our patients, but it is fairly representative, except that I should like to have included one or two of the many attractive reed lamps they have made. Basketry, of course, has been the most popular craft. In eight months we have used about 300 pounds of reed, which will give you an idea of the large number of baskets, trays, and lamps that have been made. Leather work has interested another group of patients. It is the useful article that appeals to them, bill folds, cases to hold their papers of honorable discharge from the army, covers for their pocket kodaks, purses and bags to give to their friends, and so on. These have been in both cut and tooled leather. The toy village was made by a young soldier from the Canadian army.

In the wards we have done a great deal of bead work, using both glass and steel beads. We have made numberless chains of sealing wax, and some of permodella, decorated with water colors. For a few weeks the making of sport hats was popular. We used canvas shapes, working them with raffia, or embroidered straw hats with wool. The basketry has been done both in the wards and in the workroom. I have used Dr. Hall's rough hewn toys for some of our bed patients and have found them helpful.

Should Not Encourage "Fads"

Most of you probably visited one at least of the military hospitals and may have seen that gaily colored thing called a "pillow top," an article distantly related to the simple white cotton Colonial mat. The making of these pillow tops spread like an epidemic through the military hospitals. The patients spent any amount of money on materials, and many people paid exorbitant prices for them. From my point of view, they are dreadful things, useless, ugly, and a waste of good materials. If we are to sanction this kind of hospital product in the name of occupational therapy, we had better stop to consider seriously what we are doing. The process used in making these pillow tops is not a bad one, although the use to which it has been put is unfortunate. It is simple, easy to do, and appeals to many. In an effort to win the boys from this craze, I have encouraged the making of wool shawls and baby carriage covers. Although shawls made in this way are not as good as if knitted or crocheted, they are at least quite serviceable. Knitting is a slower process, and few of the men who have made these knotted shawls could be persuaded to knit. But I was filled with grave doubt the other day when I went in to see one of our patients, who had been making a lot of shawls. I had not realized how many, as he had supplied his own materials. He said, "I have made over a hundred, I have them on sale in six cities, I get from ten to fifteen dollars for them." He had two patients assisting him, and a third to whom he was "teaching the trade." O, thought I, have I started an industry perhaps almost as undesirable as the craze for pillow tops involving, maybe, a doubtful use of good materials? I leave you to examine the shawls in the exhibit and to judge for yourselves.

We have been struggling with certain problems in connection with our occupational work which are probably not peculiar to a Public Health hospital, and are therefore worth calling to your attention. One of the most important of these problems, from the point of view of the patient, has been the difficulty in arousing sufficient interest among the physicians to persuade them to put the work on a prescription basis, and to give it the careful medical supervision it should have. We have been left to work with any patients we could interest, without knowing very much about their physical and mental condition. The absence of medical supervision in the case of our tuberculous patients has caused me special concern. They are usually most eager to work, and of course should be carefully watched.

We have failed to reach patients who will work only on a doctor's order. On the other hand, in our type of hospital, there are many coming in for examination only, who cannot be regarded as sick men, or in need of a diversional or curative occupation. Still others are well enough to take advantage of the classes of the Vocational Bureau. In the absence of prescriptions we have had no way of knowing which these patients were, nor have we had any authority to refuse them work, so that much time and materials have been expended upon them that should have been saved for those who really need our help. I am glad to say that three weeks ago our medical officer in charge issued orders to the physicians, placing occupational therapy upon a prescription basis. It is too early to report on the results, there will naturally be a few weeks of difficult transition, but I hope it will be successfully carried out, and will put our work on a sounder basis. I sometimes question the wisdom of introducing occupational therapy into any hospital unless it is given medical supervision from the very beginning.

Ask Patients to Make Certain Things

Prescriptions will also help to emphasize the therapeutic purpose of occupation, and assist us in eliminating certain undesirable practices which have developed in some hospitals. Among these I want to mention one, which from the point of view of the welfare of the patients I consider serious, and which should be checked before it becomes a custom. Some physicians, nurses, and other employees have formed the habit of asking the patients to make things for them. It is not always desirable from a therapeutic standpoint to allow the patients to do this work, especially if it means making the same articles over and over again. In an effort to check this I have asked that all such requests should first receive the approval of the director of occupation. Like many other regulations in the interest of the service, however, we have found this difficult to enforce. Not until the physicians come to regard occupational therapy as a purely medical service, to be governed by prescription, shall we succeed in establishing the right attitude toward the work among both the patients and the personnel.

This naturally leads to the question of the disposal of the products of hospital occupations. In the Public Health Service we have fallen heir to many customs that prevailed in army hospitals during the war. Little attempt was made to control the sale of the products of occupational therapy. The sentimental public often paid really ridiculous prices for things made by the soldiers, quite regardless of the quality of workmanship, or the intrinsic value of the articles. The result is that many of our

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Public Health patients have an exaggerated idea of the money value of the things they make. Hospital products should be sold through authorized channels only, and at reasonable prices, on the basis of the quality of the work. They should be sold strictly on their merits, and a standard maintained comparable with that of similar handwork done outside. Anything falling below this standard should not be sold. This should be true whether the article is sold for the benefit of the individual patient, or to secure funds for maintaining the service. The question has arisen as to whether the control over articles made from materials bought by the hospital can be extended to cover also those made from materials supplied by the patients themselves. It would seem advisable that the same regulations should govern the sale of all work in hospitals, regardless of the source of materials.

The need of improving the quality of hospital products, and the means we might employ to this end; the value of good design and workmanship; the grade of tools and materials provided; the need of more suitable workrooms and workshops in many hospitals; the problems involved in the financial aspects of the work; these are all subjects of vital interest to us. But perhaps most important at the present time is the question of the qualifications that should be required of teachers of curative occupations. May I say just a few words in regard to this.

Skilled Worker Appreciated

It has been my experience that the service of the poorly qualified reconstruction aide is not satisfactory from any point of view. The sick appreciate the skilled worker and the good teacher as quickly as any one. You cannot appeal to grown men and women, in possession of their normal mental faculties, with trivial things, or by kindergarten methods. If you want to win their interest you must offer them something worth doing, and provide teachers who know the technic of the crafts they teach, and are also tactful, sympathetic, alert, and thoroughly interested in their work. Technical knowledge should be so well grounded that a teacher can give her undivided attention to her patient, and to the effect of the work upon him. If she is instructing in basketry and must stop to puzzle over the next step in weaving a border, or how to put on a handle, she will in all probability lose the interest of her patient and find it difficult to keep him at work.

We cannot of course expect occupational teachers to be experts in all the crafts that may be taught in a hospital, but it seems quite reasonable to require that they should have thorough knowledge of at least one or two, and sufficient experience of most of the simple forms of handwork to enable them to acquire further technical points as rapidly as they need them.

Sometimes Has Not Right Attitude

The inexperienced worker coming into hospital service without any special training in occupational therapy is at a disadvantage in other ways also. Very often she does not know how to deal with sick people, and she sometimes fails to maintain the right professional attitude toward her patients. She is apt to be overwhelmed by conditions she finds. Her ignorance of hospital customs often brings her into conflict with other employees, and places her in a very unhappy position.

In the absence at the present time of a sufficient number of well trained men and women to meet the demand for occupational therapists, there is grave danger of this work falling into the hands of amateurs, and inexperienced workers. I believe this conference can help in some measure to prevent this by adopting at least a minimum standard of education, special training, and experience that should be required of all occupational teachers.

THE WATCHED POT

Medical men are getting hold of occupational therapy at the two ends and working up toward the middle. Perhaps the majority of us look upon it as diversional and are content with that. There are other men who see only the mechanical or orthopedic possibilities. Those of us who are devoted to occupational therapy in its comprehensive sense are not troubled by what seems to us partial or restricted views. We know that time will demonstrate the larger values to those who will use the principle at all.

Dr. John H. Arnett, in the July number of the *American Journal of the Medical Sciences*, says, "instead of looking upon it as a means of amusing and diverting the patient, a study was made to determine just which muscles and joints were brought into play by each occupation."

Occupational teachers should, as far as possible, get specific instructions from the doctors in charge of their cases. We may do harm by over-stretching atrophied muscles and tendons, and it is possible to fail of specific accomplishment by neglecting to use effectively the muscle groups that are most in need of development. Excellent results may follow the daily use of a screw driver as a wrist exerciser, but we must remember that any occupation, which has for its sole purpose the exercise of a single muscle or joint, may prove disheartening in results because the patient consciously, or unconsciously, resists the motion that hurts, or is difficult, and that the chances are many to one that the occupation devised for the benefit of a muscle group will not be interesting. If the work is not interesting there will be no enthusiasm and we shall miss the development of morals, without which occupational therapy loses much of its medical value.

In the pursuit of a desirable and specific end, we shall do well to remember the principle of indirection. Give the patient some really interesting work which is within his strength and which involves the use of many muscle groups, and he will invariably use the affected group also. Moreover, being off his guard, he is likely to use that group to much better advantage.

Dr. Arnett, in the article mentioned above, speaks of the value of recording instruments and of a system of records which plots out and makes a graph of improvement. He says truly enough that the patient will be interested in these measurements and will work hard for a good showing. My own experience would prompt me to use such instruments of precision very rarely, or at long intervals, and when there would be evidence of very considerable gain, on the principle that the daily watching of slow improvement is likely to be discouraging to the patient. "The watched pot never boils."

ERROR CORRECTED

Our attention has been called to an error in the name of one of the doctors mentioned in the article, in our August issue, on "West Baden as a War Emergency Hospital." The last line on page 122 and the first two lines on page 123 should read "Captain Charles S. Rebuck of Harrisburg, Pa., a graduate of the College of Physicians and Surgeons (University of Maryland), Baltimore, Md., treated diseases of the ear and throat."

Another Mystery Cake

Can You Name It?

THE first Royal Mystery Cake Contest created a countrywide sensation Here is another cake even more wonderful. Who can give it a name that will do justice to its unusual qualities?

This cake can be made just right only with Royal Baking Powder. Will you make it and name it?

$500 For The Best Names

For the name selected as best, we will pay $250. For the second, third, fourth, and fifth choice, we will pay $100, $75, $50 and $25 respectively. Anyone may enter the contest, but only one name from each person will be considered.

All names must be received by December 15th. In case of ties, the full amount of the prize will be given to each tying contestant. Do not send your cake. Simply send the name you suggest with your own name and address, to the

ROYAL BAKING POWDER CO., 162 William St., New York

HOW TO MAKE IT

Use level measurements for all materials

½ cup shortening
1½ cups sugar
Grated rind of ½ orange
1 egg and 1 yolk
2½ cups flour
4 teaspoons Royal Baking Powder
1 cup milk
1½ squares (1½ ozs.) of unsweetened chocolate (melted)
¼ teaspoon salt

Cream shortening. Add sugar and grated orange rind. Add beaten egg yolks. Sift together flour, salt and Royal Baking Powder and add alternately with the milk; lastly fold in one beaten egg white. Divide batter into two parts. To one part add the chocolate. Put by tablespoonfuls, alternating dark and light batter, into three greased layer cake pans. Bake in moderate oven 20 minutes.

FILLING AND ICING

3 tablespoons melted butter
3 cups confectioner's sugar
2 tablespoons orange juice
Grated rind of ½ orange and pulp of 1 orange
1 egg white
3 squares (3 ozs.) unsweetened chocolate

Put butter, sugar, orange juice and rind into bowl. Cut pulp from orange, removing skin and seeds, and add. Beat all together until smooth. Fold in beaten egg white. Spread this icing on layer used for top of cake. While icing is soft, sprinkle with unsweetened chocolate shaved in fine pieces with sharp knife (use ½ square). To remaining icing add 2½ squares unsweetened chocolate which has been melted. Spread this thickly between layers and on sides of cake.

ASSOCIATED RECONSTRUCTIONISTS

By MARY J. J. WRINN, Editor, The Re-Aide's Post, New York City

THE activities of reconstruction aides during the World War have stimulated the development of three national societies: the National Society for the Promotion of Occupational Therapy, the American Women's Physical Therapeutic Association, and the National Association of Ex-Military Reconstruction Aides. The three societies have distinct though related purposes.

Both occupational therapy and physiotherapy had been employed to some extent for years before the war. But the principles underlying their use were not generally known. The World War brought them to the light, and the "fads" proved their own effectiveness.

In order not to lose the ground that occupational therapy was fast gaining during the early months of the war, a group of enthusiasts, calling themselves the National Society for the Promotion of Occupational Therapy, banded together. Since that date in 1917, the society has developed into a well organized body, the influence of which is far-reaching.

Members of the society are divided into four types: active—persons in any way engaged in occupational therapy; associate—those who, seeing the importance of the idea, want to contribute to its development; sustaining; and honorary members. The object is to assist in the establishment of occupational systems in hospitals and sanatoriums, and to coordinate the activities of all charitable organizations using or directing the work.

State O. T. Societies Connected with National

The National Occupational Therapy Society is the fountainhead of state occupational therapy societies in the District of Columbia, New York, Illinois, Wisconsin, Missouri, Maryland, Massachusetts, and Michigan. The aims of the society have been realized to the extent that the word "promotion" is no longer felt necessary as a component part of its name, and a change is being considered.

Officers of the N. S. P. O. T. are: Dr. Herbert J. Hall, president; Dr. Floyd Haviland, vice-president; Miss Marion R. Taber, treasurer; Mr. Louis J. Haas, secretary. Mrs. Eleanor Clarke Slagle, Mrs. Carl Henry Davis, Miss Susan E. Tracy, R.N., Mr. Thomas B. Kidner, and Dr. W. R. Dunton, Jr., act as a board of management. The occupational therapy department of THE MODERN HOSPITAL serves the purpose of an official journal.

To meet the needs in the physiotherapy field in somewhat the same way that the N. S. P. O. T. has met them in the occupational field, the American Women's Physical Therapeutic Association was formed last March. It is the youngest of the national societies. It is the outgrowth of an association formed at Walter Reed Hospital, Washington, D. C., early in 1920.

Three classes of members are admitted to the society: charter members—reconstruction aides in physiotherapy with a total of one year's training and experience in the Army or the Navy of the United States or its Allies, provided that such reconstruction aides apply for membership by next March; active members—graduates of recognized schools of physiotherapy or physical education who have had training and experience in electrotherapy and hydrotherapy; honorary members—graduates of medical schools conforming to the standards of the American Medical Association. The objects of the association are to advance physiotherapy as a profession, to standardize the work, to disseminate medical literature of professional interest to its members, to secure positions for its members, and to sustain social fellowship and intercourse upon grounds of mutual interest. With these ends in view, the *P. T. Review* made its first appearance last month as the official journal of the organization.

Officers of the A. W. P. T. A. are: Miss Mary McMillan, president; Miss Beulah Rader, Miss Emma Heilman, vice-presidents; Miss Janet B. Merrill, treasurer. Miss Hazel Furchgott and Miss Marien Sweezey constitute an executive committee. At this writing, the secretary, to be appointed by the executive committee, has not been named.

The Physio Society has local chapters in New York, Boston, Chicago, Los Angeles, San Francisco, the District of Columbia, Portland, Ore., and New Haven, Conn.

Ex-Service Aides Have Society

Many members of both these societies, united by the common bond of service with the colors, are members also of the National Association of Ex-Military Reconstruction Aides. Men and women who served during the World War emergency as occupational or physiotherapy aides in the Medical Department of the United States Army, are qualified for membership in the military society. The aim is a social one—to augment the friendships and interests developed during the period of service. Furthermore, in the event of another emergency, the members, an experienced group, tried out in the fires, stand ready to serve if needed.

This National Association of Ex-Military Reconstruction Aides is the development of the Fort Sheridan Society of Military Aides founded at Lovell Hospital in May, 1920. One of the objects of the Sheridan body was to effect as soon as possible a national association. With the attainment of that purpose, it ceased to act as the Sheridan Society, became in effect the National Military Association, and as such began formally to function on December 13, 1920.

The national society retained the officers, board of directors, and journal of the Sheridan Society. The officers of the present society are: Miss Belva Cuzzort, who suggested the idea of organizing, president; Miss Susanne Gough, vice-president; and Miss M. Estelle Angier, secretary-treasurer. The board of directors, which, in the Sheridan Society, had been the organizing committee and the nominating committee, consists of Miss Margaret McNamara; chairman, Mrs. René W. Pintó, Mrs. Edith A. Ruehl, and the writer, occupational therapy members; and Miss Mabel Magness, Miss Alice Ueland, Miss Zaidee Bonney, and Miss Dora E. Ellis, physiotherapy members.

Through a four-page paper, the *Re-Aides' Post*, a year old next July, the members of the society, scattered in all the states of the Union, in England, France, Canada, and the Canal Zone, are held together. The paper prints articles by leaders in the fields of occupational and physiotherapy, news of association progress, feature stories, gossip; in brief, news of everything and everybody in any way connected with the work of aides. A column, "Echoes of the Ward," is reserved for news of former patients. The little journal takes subscriptions from interested persons outside the association.

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SURGEONS' GOWNS

and PATIENTS' BED GOWNS

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Sizes: Small, Medium, Large

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No. 846—Heavy Indian Head Cloth; 60 inches long, with long sleeves; perfectly cut from material that resists chemical action and blood stains.
Per dozen $18

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Comfortable, well-fitting garments of Pepperell Cloth or Indian Head, double yoke front, wide hems and tapes in back, 36 inches long, long sleeves.
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An activity of the society to which the last *Re-Aides' Post* gave considerable space is the gathering of material for a history of the aides' work in army hospitals. In so far as it has been planned, the history is to be a human interest narrative.

Societies Do Not Overlap

To the casual observer it may appear that three such societies as the N. S. P. O. T., the A. W. P. T. A., and the Military Aides' Society, must encroach on one another's domain and so lessen the influence that might be exerted through union. On the contrary, the strength of the societies is in their very separateness. Each has its special aim which must be furthered through its own sponsors. The societies are not rival teams. There is every reason for sympathy and cooperation. Membership in one seems to imply something like a tacit belief in the high purposes of the others.

Indeed, that belief is not wholly tacit. Many members of the military society, for instance, are members of the N. S. P. O. T. or the A. W. P. T. A., and larger numbers will rally to their support as their existence and aims become known. Membership in more than one of the societies does not mean a duplication of interests. Except for the social clause in the constitution of the physio society, there is no repetition of purposes, and that clause expresses a secondary aim.

The great problem of rehabilitation is the underlying interest of each of the societies, whether formally or informally expressed. For that, will the N. S. P. O. T. strain its energies to the scientific advancement of occupational therapy. And who will question the attitude of the Military Aides' Society toward the great work? Were not all its members of those who actually blazed the trail through difficulty and discouragement? They treasure their tradition. Their pioneer experience demands that they exert an influence for the great cause at issue.

Recruited as they are from many and varied professions, they can exert all the wider influence. Many have it in their power to carry the gospel into communities that still see as boundaries of the curative realm, only the medicine bottle and the surgeon's knife.

In its informal way the Association of Ex-Military Reconstruction Aides may be a powerful force in pushing the work of the other societies and in so doing, lose neither its spirit nor its identity, for rehabilitation is surely an interest which the period of service developed from the very first moment when the aide ventured forth at the challenge: "Enter these enchanted woods, you who dare."

A SUCCESSFUL AUSTRALIAN EXPERIMENT

Of interest to both occupational therapists and governmental departments dealing with the replacement of ex-soldiers is an article in the *American Wool and Cotton Reporter* entitled "Hand Loom Weaving for Returned Soldiers." The article relates the successful experiment on the part of the Repatriation Department of the Australian Government in its factory at Melbourne where ex-soldiers are taught the weaving of tweeds on hand looms. The government experienced such good results from this project that it turned over the factory to the soldiers, themselves, each of whom has an interest in the plant, these holdings being today worth from $750 to $1,000. The industry is governed by a trust comprising three directors chosen by the Soldiers' League and is entirely free of official control.

The British Government shortly after the armistice instituted a somewhat similar industry in an effort to aid disabled soldiers and sailors, and it is gratifying to note that cloth merchants as well as cloth consumers are giving every possible encouragement to this commendable enterprise.

"About the same time, our own government gave the matter serious consideration, and went so far as to invite skilled woolen mill workers to qualify as instructors of ex-service men in this particular line of work. Up to date, there appear to have been no further steps taken to advance the project." Surely, it cannot be that the services of war veterans are less appreciated in this country than in any other.

This employment of hand loom weaving is peculiarly adapted to the disabled. Simple but good looking twills in the line of homespun suitings can be made with comparative ease by the worker on a loom of simple type, easily operated, and which does not demand the weaver's constant attention. "He sits on a slanting seat, fixed at the front and center part of the loom, with both legs and feet reaching well down to the treadles; then with the left hand grasping the loom lathe and the right hand the hand pin, he operates the treadles with his feet and the lathe, with shuttles, with his hands, at a speed to suit himself." For those who are further incapacitated by the loss of a leg, provision may be made by means of another type of hand loom which has only a single treadle.

Power Loom Would Not Give Result

In answer to the probable question, "Why not introduce the power loom, thereby increasing production and profit?" it may be said that while commercialism and profit do enter in to a certain extent, these are not the chief aims of the enterprise. The object in view is a vocation that will be health-giving to both body and mind, and this object cannot be realized with the power loom with its "continuous confusing noise from revolving shafting and heavy machinery, together with the necessary active attention to a quick running, somewhat complicated machine." Even to a person of good health, such work is nerve-racking, and its adoption for the handicapped would spell failure.

It is hoped that our own government will not be slow to follow the example of that of the Repatriation Department of the Australian Government, in establishing hand loom weaving for the returned soldiers on a sound industrial basis.

LOVE'S LABOR LOST

During the American Medical Association convention in Boston, doctors from many states visited the occupational therapy shops at Marblehead. The aides on duty enjoyed the task of demonstrating the several departments. One day, two well dressed and alert looking men strolled into the shop and were evidently much interested in the weaving. At the end of a complete inspection, they seemed a little uneasy and finally told the aide that they were steam fitters and had come to repair the boiler.

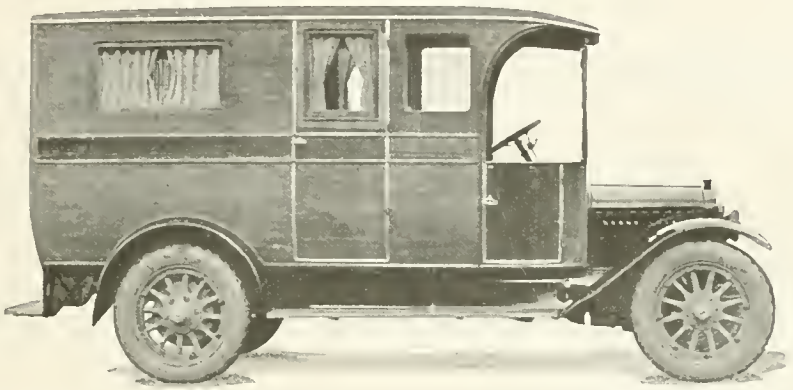
A DEFICIENCY

In a letter to the editors, Mrs. Eleanor Clark Slagle says: "I have yet to find an occupational therapy pupil other than a nurse, who is sufficiently grounded in anatomy and hygiene."

"Nurses are learning that the convalescent period calls for something more than attention to the physical needs." —Aileen Cleveland Higgins.

GMC

AMBULANCE



GMC ambulances have proved their reliability in thousands of instances under the most trying circumstances.

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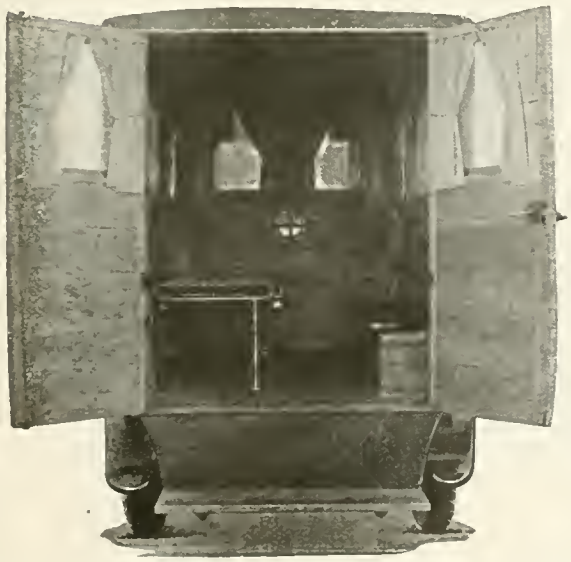

An ambulance may have any type of body or interior equipment to meet the views of any hospital director.

The important features, however, are the chassis and the motive power. Safe, quick and comfortable transportation for the patient is the main requirement. These are found in the GMC.

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Hints to Hospital Superintendents

THINGS YOU CAN HAVE AND DO

WHEN inspiration runs low and we feel ourselves settling into that rut, almost imperceptible—especially to ourselves—the best thing is to go out and see what someone else is doing. And so in imagination come and walk around Wesley Memorial Hospital, Chicago, with its superintendent, Mr. Gilmore, and let him explain to you many clever devices which any hospital may have, because they are the product of ingenuity rather than money. That is the kind that we are looking for today. And more important than devices and explanations let yourself feel the spirit of homelikeness and kindliness which pervades the hospital.

Smoking Room On Roof

We go to the top floor of the hospital and work down. On the top floor is a roof garden partly enclosed and partly open to the breeze. In the enclosed part is a small room, a smoking room for the men patients. It is quite a homelike little room and on one side stands a large cabinet filled with curios. Someone "with an understanding heart" as Opal Whiteley would say, placed this interesting collection of things picked up in all parts of the world in the best place to have it enjoyed. An ever changing group of people with plenty of leisure for curios may stand entranced before the glass doors. Why do not more of such things end in hospitals rather than in musty museums where tourists have no time to stop and enjoy them? In another part of the sun parlor and indeed all over the hospital are drinking fountains low enough so that a man in a wheeled chair may comfortably get a drink. In the sun parlor also are two parrakeets whose bright coloring is a joy to the eye although their conversation is not particularly musical.

Use Phone Call System

As we descend to the next floor we hear a nasal voice calling someone, and discover that the hospital uses the phone system of calling and has found it very satisfactory. By this means anyone may be called— doctors, interns, nurses, or visitors. Then they step to the nearest phone and take their call. The silent system of lights has been discarded for what the hospital considers a surer system.

We step into an operating room and the first thing that catches our eye is a chamber outside of the skylight. This chamber is about three feet in depth and has steam coils inside it so that the warm air from the room is kept from condensing on the otherwise cold glass and dripping down the window pane. This plan has been adopted by the architects of a number of hospitals. This operating room may be entirely air tight for those physicians who prefer it that way, but for those who wish ventilation there is a fan set in a little compartment in the wall which can force air into the room. Sometimes it is possible to please everyone.

Near the operating rooms are two small rooms fitted up as laboratories for the doctors who may wish to do certain laboratory work themselves, or have the interns do it under their direction. These are entirely separate from the main laboratory and Mr. Gilmore has often been assured by his staff that they are the greatest comfort of anything in the hospital.

In a cabinet we find "dressing baskets" of three compartments fitted with everything the doctor will need in making his dressings.

In the corridor stands a Victrola on wheels, and on its rubber tires the Victrola with its records may travel to any part of the hospital.

The nursery has a small dryer which pulls out and then may be pushed back out of the way. In the center of the room is a table, hospital-made, which has a center shelf for supplies and which allows the nurses to work on both sides.

As we walk around we are enchanted by the colors on the walls. They are different shades of yellow, buff and other colors, as the light in the room makes advisable, put on with the "Tiffany finish" which looks like Tiffany glass. As one patient explained, this is so much more interesting than a flat finish for it always looks different. You can see figures in it as you might in the clouds. The hospital can do this because it has its own painters which it keeps busy all the time. Some of the private rooms are finished in a way which any private home might be proud of—white panelled walls with a border of hand painted roses around the top. Across the corner of the rooms is a small closet sufficient for the patient's wardrobe and yet taking up very little space. The lighting in the rooms is indirect with bedside lights. The chairs are very unusual—not institutional at all, just comfortable. Most of them are big leather chairs with wing sides, bought ten years ago, when leather was made to wear long. They more than anything else give the homelike touch to the room. Instead of the bedside table the hospital uses bed top tables which fit over the patient's knees. The radiator has a top built over it making it serve as a table and enhancing its beauty. Every room has a telephone with a private wire.

Wards Have Glass Partitions

Mr. Gilmore has an excellent arrangement in the wards. One end of the large twenty-four bed wards is shut off by a glass partition. Here the patients who like plenty of fresh air and whose conditions call for it may be as cool as they wish without freezing the other patients. Noisy

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PROVE

the food and regulatory value of

KELLOGG'S BRAN

cooked and krumbled

IN a nation so widely afflicted with constipation personal knowledge of what Kellogg's Bran, cooked and krumbled, can mean to your patients' and to your own health is a matter of utmost importance.

Kellogg's Bran, cooked and krumbled, must not be confused with common or "cooked" bran. Kellogg's Bran is simply delicious in the nut-like flavor of its krumbled, toasted flakes. Yet, it is so rich in vitally needed mineral salts and supplies so much real "roughage"—which stimulates intestinal activity—that it must be regarded as an ideal regulative food. In fact, Kellogg's Bran, eaten regularly, will permanently relieve constipation, naturally! Physicians indorse the use of Kellogg's Bran for constipation.

Eat Kellogg's Bran as a cereal, sprinkled on or mixed with other hot or cold cereals or use it in countless appetizing ways such as in bread, muffins, gems, cookies, drop cakes, etc. Recipes on each package. Kellogg's Bran Griddle Cakes win the fussiest appetite! Oatmeal takes on a new and health-making interest when cooked with Kellogg's Bran. Add ½ cup of Bran to 1 cup of oats and 3 cups of water and cook as usual.

Kellogg's
BRAN GRIDDLE CAKES

1 cup Kellogg's Bran; 1 cup flour; 1 tablespoon sugar; ½ tablespoon butter substitute; ½ teaspoon salt; 1 teaspoon baking powder; 1 cup milk; 1 egg. Mix dry materials, add egg slightly beaten and milk and butter substitute. Beat thoroughly and bake on a hot griddle. Serve with butter and syrup. This will make 20 cakes.

Kellogg's
BRAN BREAD

2 cups Kellogg's Bran; 1 cup boiling water; 1 tablespoon shortening; ⅓ cup molasses; 1½ teaspoons salt; 1 compressed yeast cake soaked in ⅓ cup lukewarm water; 4 cups flour. Pour boiling water over Bran. Let stand ½ hour. Add melted shortening, molasses, salt, yeast and flour. Beat well and let rise. Turn into buttered bread pans. Let rise again and bake for one hour.

Kellogg's *Look for this signature W. K. Kellogg*

the original BRAN - *cooked and krumbled*

Consult the 1920 Year Book for Catalog information.

patients may be placed here, or patients coming out from under anesthetics. This division makes the ward more quiet and lessens confusion during visiting hours. Mr. Gilmore intends to make a third division in the wards, for it takes no more of a nursing staff as the nurses on duty can look right down through the wards and command the whole room as if the partitions were not there.

Going down to the next floor we walk down the inside fire escape which is occasionally seen in other hospitals. It is made of concrete and marble and has the great advantage of allowing the patients to get down without going outside.

The linen which we pass in large hampers on its way to the proper ward we notice is marked with several figures. These indicate the time it was put out and the floor to which it belongs. This is a check on the floor, to see if it is using its linen carelessly, on the linen, to see if it has the proper wearing qualities, and on the laundry, to see if it is sending back all the linen to the proper floor.

Mother Goose Rhymes On the Wall

In the children's ward we find, besides the elaborate Hallow'en and Thanksgiving decorations, Mother Goose rhymes, with illustrations, decorating the walls. Could anything be more delightful than for children to look up and see, not blank walls, but these ever new and interesting tales to be pondered over and learned by heart? Outside of this ward white gowns are given out to visitors for fear they will carry infection in from the street car or train.

There is a library in the hospital having on one side books of beautiful bindings which belong to the hospital, and on the other side many of the latest books from the Chicago Public Library, of which the hospital is a branch. The Public Library changes the books as often as the hospital wishes. Books are given out to patients here and for those who are not able to come to them the books go out on a little cart.

The hospital has no trouble with having silverware taken off for souvenirs because the nurse is responsible for the set which her patient uses. In ten years no pieces have disappeared.

Next we see a piece of apparatus which is sold by several reliable firms, but which is here made in the hospital. It is a half cylinder of galvanized tin, with from seven to nine sockets for electric bulbs, which fits right over the patient as he lies in bed.

A machine for exercising the muscles of the arm, hand and fingers, which would have cost about $100.00, was made at very little expense by the engineers of the hospital. It is a wooden table with little things of various weights which may be pushed or pulled. At one end is a roller of graduated sizes which may be turned around. Many patients after they leave the hospital come back to do exercises here.

We have seen many other things from the wonderful electrocardiograph to the diet kitchens—but we are looking for the things today which any hospital might have with the exercise of ingenuity and skill.

Then there is the thing which we have found which any hospital might have with the exercise of great wisdom and patience. That is the spirit of human interest and hospitality. The patient is treated as if he were a guest in a private home. This spirit pervades the whole staff, from the nurse who stops to speak to a patient and perhaps get a glass of water though it is not her patient at all, to the superintendent who devotes an extra three hours a day to making the rounds and calling on every "guest" in the hospital.

HOW TO TEST ENAMELED IRON WARE

Many hospital buyers find extreme difficulty in judging good enamel ware, not only surgical utensils, but also cooking ware and enameled plumbing fixtures.

Although the quality of the ware can be judged somewhat by the appearance; by the absence of roughness, blisters, bubbles, and bare spots; and by gloss, and freedom from hair cracks and peeling, the real resisting quality cannot be readily determined except by use. Enameled ware readily roughened by the application of diluted vinegar should be under suspicion. The question as to whether the enamel sets free such injurious substances as lead and antimony can be determined only by the chemist. The use of either of the above metallic oxids should be prohibited for cooking ware, although allowable in sanitary ware. Care should be taken to prevent contact of acids of all kinds, including vinegar, with enameled surfaces. On no account should bathtubs and basins be cleaned with acids, but soda or alkaline cleaning compounds should invariably be used. A simple test of enameled ware consists in applying either black or red ink to the surface and allowing it to dry. Upon washing it off with clear water no faint stain should be left.

CONSERVATION OF COAL DID NOT END WITH WAR TIME

The Bulletin of the Winnipeg Municipal Hospital gives a timely suggestion concerning the familiar subject of the "Conservation of Coal":

Please bear in mind that every radiator giving off heat which is not necessary for your comfort is a definite and needless waste of coal.

Remember to turn off radiator when you do not need the heat just as you do the electric light when you are not using it.

The cost of running the hospitals is great. Do your part in reducing it by careful observation of the principles of economy in everything you do. It is the little things that count. A penny saved is a penny earned.

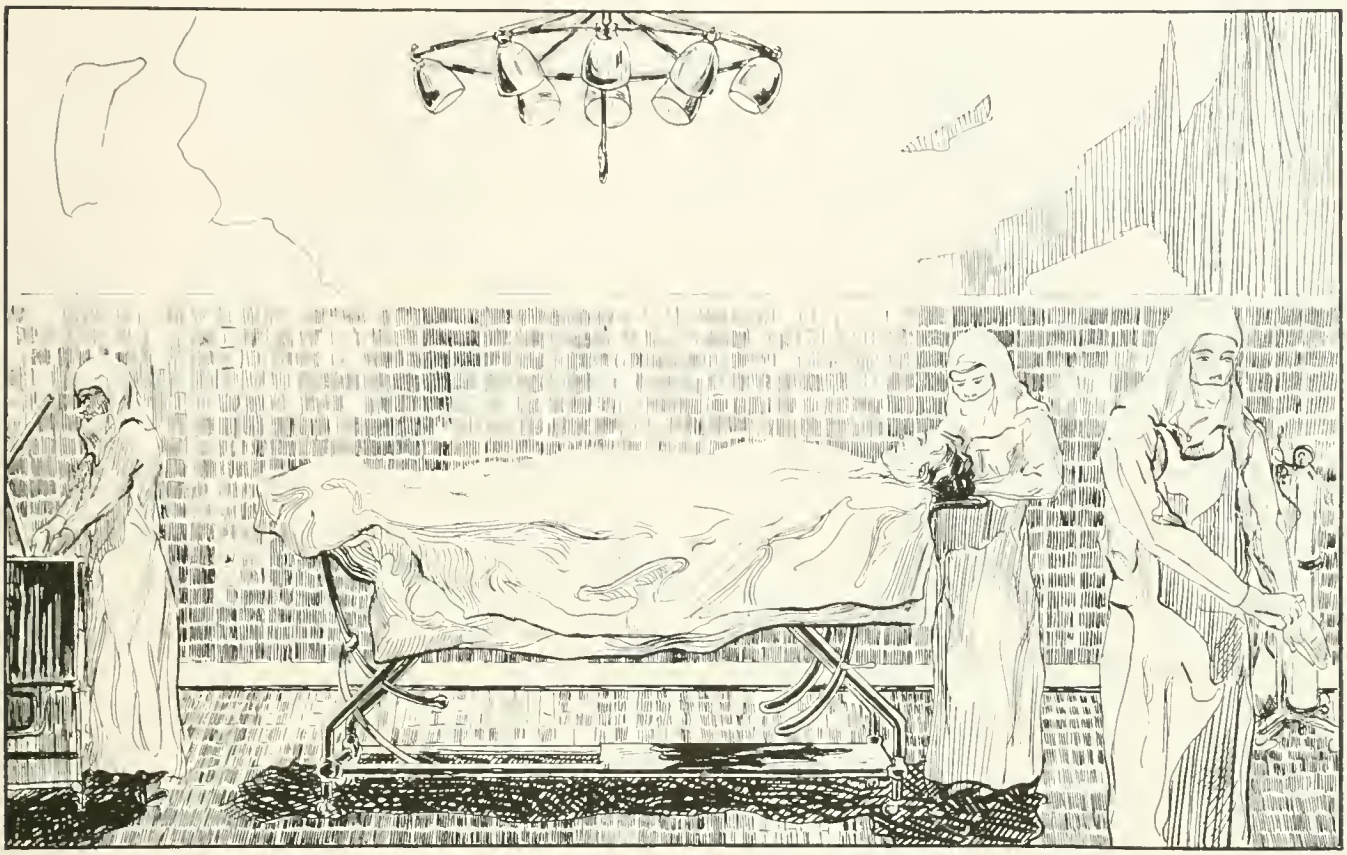
UTILIZING OLD BLANKETS AND GAUZE DRESSINGS

Mr. Bacon, of the Presbyterian Hospital, Chicago, made a suggestion at the meeting of the American Hospital Association at West Baden, that is worth passing on. When rubber sheets become old instead of throwing them away, cut them in half, insert a new piece of rubber in the middle and use the old pieces at the sides to tuck under the mattress.

Another superintendent said that in the matter of surgical dressing a substantial saving had been accomplished in his hospital by having the dressing made large at first and then after every washing cutting off the edges which puts them into the next smaller class. This eliminates the frayed edges and greatly lengthens the time which it is possible to use the dressings.

HOSPITAL BOARD TO BE INVESTIGATED

Representative Fitzgerald of Ohio recently introduced a resolution in the House calling for an investigation of the consultant board of physicians appointed by Mr. Mellon, secretary of the treasury, to select sites and make recommendations for the expenditure of $18,600,000 voted by Congress to provide hospital facilities for ex-service men.



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Book Reviews and Current Hospital Literature

THE MANAGEMENT OF MEN

A Handbook on the Systematic Development of Morale and the Control of Human Behavior. By Edward L. Munson, Colonel General Staff (Med. Corps); Chief, Morale Branch, War Plans Division. (Lately Brigadier General, General Staff). Prepared with the assistance of Arthur H. Miller, Major, Coast Artillery Corps.[1]

"Morale" is a word which has become quite common in newspaper text as well as in conversation since the beginning of the late war. As is the case with so many of our words adopted from the French, the meaning of morale is not always explicit. If the author of "Management of Men" had done nothing more than define the elusive noun "morale" he would merit the thanks of those who use speech to convey thought.

In putting together his material, the author has created a textbook, the first of its kind. It is really a textbook compiled from the results of a great laboratory, for after all, during the war, the army was a great synthetic laboratory, experimenting, analyzing and finally producing as a finished product, the American Soldier. It was the duty of the Morale Branch of the General Staff to collect and utilize the results of the four million experiments resulting from the recruiting and draft campaigns.

This book is not one which can be read; it must be studied and it will repay study. It is a book which can only be absorbed slowly, so crammed are its pages with the concentrated results of wide experience and philosophic deduction.

At the start, reading "Management of Men" is somewhat tiresome due to the author's following the psychological axiom that to tell a man a thing often enough is to have him finally believe it. But after one is fairly into the book, one reads on in spite of himself. While written by an army officer and of necessity focused on the army viewpoint, the worth of Colonel Munson's book is by no means limited to the military minded. The chapter on industrial morale alone should place the volume in the hands of every industrial executive, for, as has been stated above, this book is the first of its kind and the kind that is badly needed, a text of instruction in the art of handling human beings. To emphasize this point, we quote from the author:

The essence of morale work is the development of qualities of leadership. The latter is the ability to handle men so as to achieve the most with the least friction and the greatest cooperation. It seems a curious oversight that with the vast amount of thought, money and material lavished on the military establishment, instruction in the human element which puts them to use, from the efficiency standpoint, has been so completely overlooked. Apparently this essential matter has been left to the individual officer on the wholly unwarranted assumption that example, common sense and experience will tell him the best way to bring his men to greatest efficiency. But good example is a matter of chance; common sense will not always serve for it must be based on knowledge, while experience often has not been extensive enough to confer such knowledge. The results as to leadership have accordingly been variable. Methods have been more or less unscientific, incomplete and empirical. The degree of success is largely a matter of personal equation. Naturally some succeed, others fail, and probably none do all that might be done under a thorough and clear understanding of the conditions to be remedied and the measures and mechanics of accomplishment.

No amount of technical training or knowledge can make an officer really efficient if he does not possess in addition the power of so controlling his men and of so directing their wills as to preserve harmony in the organization and bring the best out of his men. There are but few right ways of handling men in any emergency, but many wrong ones. The way should be chosen which will give the results desired with the least interference with human instincts and interests. This should not be left either to intuition or chance. Systematic study of human nature makes both unnecessary.

Hospital superintendents will find much of great interest and more of great value in the pages of the "Management of Men" and the section on "The Commanding Officer" (page 308) is especially recommended. As time goes on, there will probably be included in the curriculum of every training school a course in applied psychology. To teachers of such courses the reviewer strongly recommends Colonel Munson's book; he has found it of extreme value in preparing his own lectures on the subject.

As a piece of workmanship, the volume is very well put together in arrangement and binding. It would scarcely be fair to review the book without a word regarding the ingenious diagrams. These charts and drawings, many of them in color, bring out, with remarkable force, the points made by the author. JOHN F. BRESNAHAN, M.D.

1. Henry Holt and Company, New York, 1921.

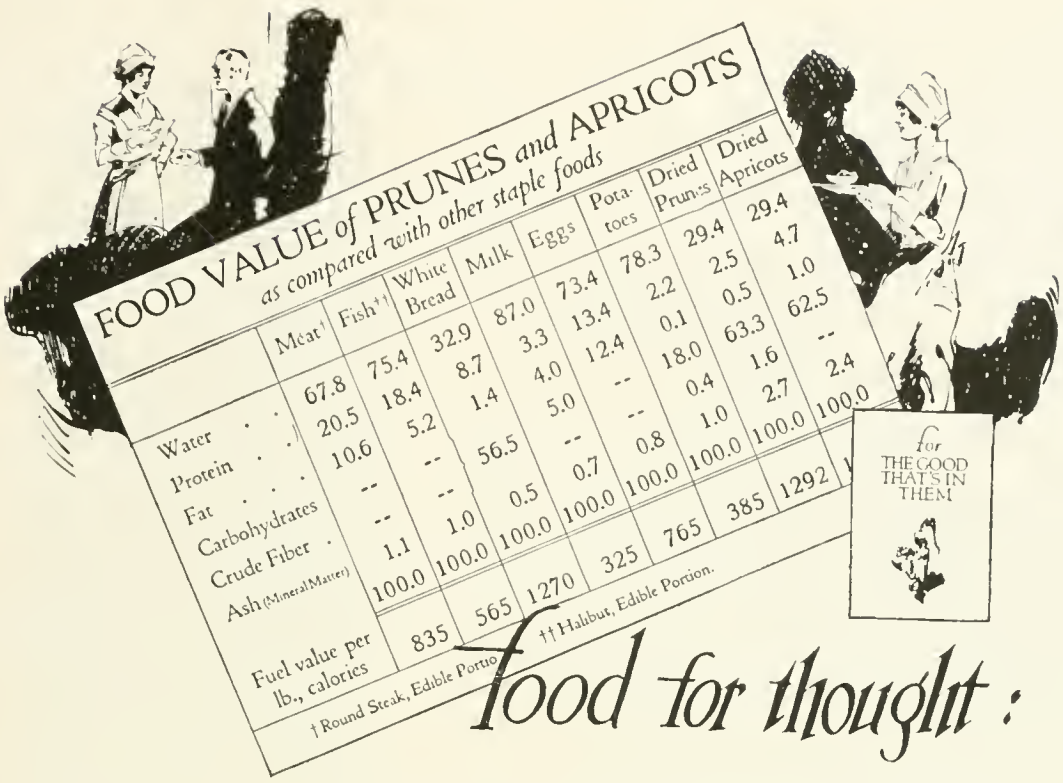
DISEASES OF CHILDREN

Designed for the Use of Students and Practitioners of Medicine. By Herman B. Sheffield, M.D., formerly Instructor in Diseases of Children, New York Post-Graduate Medical School and Hospital, and Medical Director, Beth David Hospital, Consulting Physician to the Jewish Home for Convalescents and the East Side Clinic for Children.[1]

This volume represents an experience in the field of pediatrics of nearly thirty years on the part of the author. Designed especially to meet the needs of the general practioner and medical student it embodies the latest information both theoretical and practical concerning the diseases of infancy and childhood.

The book is divided into fourteen sections, the classification of the diseases corresponding to the modern conception of the causation of the disease in question. The discussion of infant feeding is based upon the most recent studies of the digestibility of protein, fats and carbo-

1. C. V. Mosby, St. Louis, 1921.


FOOD VALUE of PRUNES and APRICOTS
as compared with other staple foods
Meat† Fish†† White Bread Milk Eggs Potatoes Dried Prunes Dried Apricots
Water 67.8 75.4 32.9 87.0 73.4 78.3 29.4 29.4
Protein 20.5 18.4 8.7 3.3 13.4 2.2 2.5 4.7
Fat 10.6 5.2 1.4 4.0 12.4 0.1 0.5 1.0
Carbohydrates -- -- -- 5.0 -- 18.0 63.3 62.5
Crude Fiber -- -- 56.5 -- -- 0.4 1.6 --
Ash (Mineral Matter) 1.1 1.0 0.5 -- 0.8 1.0 2.7 2.4
Fuel value per lb., calories 835 565 1270 325 765 385 1292
† Round Steak, Edible Portion. †† Halibut, Edible Portion.
for THE GOOD THAT'S IN THEM

food for thought:

Forget, for the moment, that prunes and apricots can be prepared in so many ways to entice the most palate-weary patient. Set aside the importance of prunes as a laxative from Nature's own pharmacy. But consider this:

Nutrition investigators generally agree that the *carbohydrates* of our food [and *not* the nitrogenous compounds] are the source of muscular energy for the body. Run your finger along the carbohydrate line in the table at the top. Prunes and apricots "stack up" pretty high—don't they?

Consider now the *mineral* matter in dried fruits. Prunes especially are high in iron. Also they contain certain salts and organic acids which improve the quality of the blood and react favorably on the secretions.

And now—consider this: the experiments of Osborne and Mendel prove that deciduous fruits furnish water-soluble vitamin; and that prunes apparently are richer in this dietary essential than apples and pears.

Food for thought? Well, rather!

Every physician, dietitian and nurse will find plenty of "dietetic meat" in our health-brochure, "For the good that's in them." Sent free! And, if you ask for it, we'll send along an advance copy of the 1922 Sunsweet Recipe Packet. California Prune and Apricot Growers, Inc., 1194 Market St., San Jose, California ~ 11,000 growers.

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hydrates and upon the author's experience. The chapter on examination of the patient is designed to aid the beginner in surmounting the difficulties in the diagnosis of infants and older children. A careful survey is presented of the most modern methods of laboratory diagnosis. The diseases of the newborn which cause such a great loss of life are gone into minutely, especially those of a septic nature. The section on respiratory diseases includes those of the nose, throat and ears. The subject of the ductless glands is treated broadly, laying stress on the diseases of the thyroid, thymus, and pituitary glands. The important subject of the communicable diseases of childhood is treated exhaustively. Syphilis and tuberculosis both receive considerable attention.

HANDBOOK OF SOCIAL RESOURCES OF THE UNITED STATES

By Genevieve Poyner Hendricks, The American Red Cross, Washington, D. C.[1]

The peace time activities of the Red Cross have brought need for information regarding the general social resources of the country, not merely in relation to soldiers and sailors as was the handbook prepared during the war. As this former book "The Handbook for Home Service Sections" is still available and kept up to date, the Handbook on Social Resources does not attempt to include information regarding agencies whose sole purpose is to render aid to soldiers and sailors and their dependents. The book does not attempt to cover activities which are purely temporary in character, nor those of a local or regional interest.

The handbook is a digest of social resources of the United States, and an endeavor has been made to include, for each organization, mention of its general program; its specific activities; the annual meeting, and whether it is open to the public; the names and work of special and standing committees and commissions; field work and lecture service, to whom available and on what terms; information service and clearing house work, and how this service may be secured; reference and library facilities; survey and investigational activities.

MATERIA MEDICA AND THERAPEUTICS—A TEXTBOOK FOR NURSES

By Linette A Parker, B.Sc., R.N.[2]

The third edition of Miss Parker's Materia Medica and Therapeutics has all the good qualities of the former editions plus much new material.

A description of the Centigrade and Fahrenheit thermometers is added to the chapter on solutions. A practical method of calculating doses from hypodermic solutions of given strength is included under Posology. A new chapter has been written on Drugs in Solution, giving in detail the description, method of action, uses and care of the solutions more commonly handled by nurses. The discussion of many of the important drugs, the central stimulants, morphine, pituitary body, ammonium, iron and ergot, has been amplified and largely rewritten. Many of the proprietary remedies described in new and non-official remedies are grouped with the drugs to which they are related, many minor additions and changes have been made to make the book more valuable.

This text, representing as it does the work of a nurse for nurses, is written from the standpoint of a trained teacher and is limited to the important and practical points which form a foundation for an intelligent handling of drugs, but not for prescribing them.

It is generally agreed among teachers that the habit of using the index of a book is an invaluable one for students to form. The classification of drugs by systems which is a unique feature of this text necessitates the use of the very complete index provided. The increased demand for this book is a gratifying indication of appreciation of the service which Miss Parker rendered in compiling it.

1. The American Red Cross, Washington, D. C.
2. Lea & Febiger, Philadelphia, 1921.

EPITOME OF HYDROTHERAPY

By Simeon Baruch, M.D., LL.D., Consulting Physician to Knickerbocker and Montefiore Hospitals. 205 pages.[1]

Dr. Simon Baruch of New York City, for a whole generation, has stood as a star advocate of hydrotherapy. His writings, especially his large work on hydrotherapy, have unquestionably been the means of introducing this important branch of therapeutics to a great number of physicians. Dr. Baruch's lucidity of expression, clearness of diction, and accuracy of statements, makes the reading of his books a pleasure. We are glad to note a new book from his pen, "An Epitome of Hydrotherapy." This work, as its title indicates, is an epitome. In two hundred cases the author presents an outline of his views on "the position of water in materia medica, rationale of hydrotheapy, the physical characteristics of water, shock and reaction, the application of water in disease, and the technique of hydrotherapy." Nearly thirty pages are devoted to the question of hydriatic installation, some fifty pages to special procedures adapted to various diseases. The book is well illustrated and will be welcomed by all practitioners who appreciate the value of water as a therapeutic means.

BOOKS RECEIVED

THE PSYCHOLOGY OF NURSING. By Aileen Cleveland Higgins, (Mrs. John Archibald Sinclair, A.B., R.N.) war relief superintendent of the Stanford School for Nurses, San Francisco, California; instructor in War Emergency Courses, University of California. G. P. Putnam's Sons, Pub., New York and London. The Knickerbocker Press, 1921.

MASSAGE AND THERAPEUTIC EXERCISE. By Mary McMillan, assistant at Sir Robert Jones' Clinic, Southern Hospital, Liverpool, England, 1911-1915; in charge of massage and exercise at Greenbank Cripples' Home, Liverpool, England, 1911-1915; supervisor of aides in Physiotherapy Medical Corps, United States Army, Washington, D. C. 1919-1920. Illustrated. W. B. Saunders Company, Philadelphia and London, 1921.

THE ASSESSMENT OF PHYSICAL FITNESS, BY CORRELATION OF VITAL CAPACITY AND CERTAIN MEASUREMENTS OF THE BODY. By Georges Dreyer, C.B.E., M.A., M.D. Fellow of Lincoln College, Professor of Pathology in the University of Oxford, Corresponding Member of the Royal Danish Academy of Letters and Sciences, in collaboration with George Fulford Hanson, Late Lieutenant U. S. A. Medical Corps, Air Service. Foreword by Charles H. Mayo, M. D., Rochester, Minn. Paul B. Hoeber, Pub., 67-69 East 59th Street, New York City, 1921.

NURSES' HANDBOOK OF DRUGS AND SOLUTIONS. By Julia C. Stimson, R.N. Vassar A. B. Washington University, St. Louis, A.M. Graduate of the New York Hospital Training School for Nurses; Superintendent of Army Nurse Corps and Dean of Army School of Nursing United States Army. 3rd ed., Whitcomb & Barrows, Huntington Chambers, Boston, 1920.

THE TECHNIC OF THE CHICAGO LYING-IN HOSPITAL AND DISPENSARY. Preface by J. B. DeLee, M.D. Copyrighted by The Chicago Lying-in Hospital and Dispensary, July, 1921.

1. W. B. Saunders Company, Philadelphia, 1920.

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FOREIGN CORRESPONDENCE

OBSTETRICS AND GYNECOLOGY UNIT AT ROYAL FREE HOSPITAL

BEFORE entering into a description of the unit of obstetrics and gynecology established recently at the Royal Free Hospital, London, it will be fitting to give a brief account of the history of the hospital in question, which holds a unique position among the hospitals of London, indeed of England. It may be said that since the year 1828, when it was the first of the London hospitals to admit necessitous men, women, and children without the usual formalities, the Royal Free has been a pioneer. In 1877, and this constitutes its chief claim to fame, it led the way in admitting women students to its wards. In 1896 it appointed women graduates as medical and surgical registrars, in 1900 it opened its resident posts to women graduates, and in 1902 it elected two women graduates to its honorary staff. The Royal Free Hospital is essentially the clinical training school for women medical students and is the only hospital in Great Britain devoted to this training. Other hospitals and medical schools admit women students, but only in strictly limited numbers, while many hospitals will not admit them at all. Owing to this fact women students flock to the London School of Medicine for Women and consequently to its hospital the Royal Free. So great has been the increase of students that the clinical facilities of the hospitals have had to be extended. It goes without saying that the efficiency of medical education depends, largely, on the number of cases to be studied, the number of cases depends on the number of beds to receive them. This being so, in 1915 a fund was started to extend the hospital, on land presented by its chairman. Donations, subscriptions and promises have reached £32,000 ($160,000); and though the school and hospital require a total of £500,000 ($2,500,000) to carry out the scheme in entirety, the work of extension has materialized so far, that a "unit" of obstetrics and gynecology has been created and 100 additional beds have been equipped for that new and hitherto somewhat neglected class of patients who do not feel themselves justified in accepting free hospital treatment, but who have no facilities for operations in their own homes, and are unable to pay the high fees of a good nursing home. The work in medicine and surgery has become more and more specialized and it was felt that the old methods of teaching by the physicians and surgeons on the staffs of general hospitals was becoming out of date, as a matter of fact, it was found that teaching in this way was not thorough. In 1913 the idea of "units" for the teaching of medicine, surgery, obstetrics, and gynecology was brought forward in the Haldane Commission on University Training, but owing to the war the matter was naturally shelved. The conception of a "unit" or team-work is that a director and two or more assistants should have under their control a certain number of beds, from sixty to one hundred, and that they should devote all their time to the treatment and care of the patients, the teaching of students, and to research work. The directors are to be chosen on their past record for good work, for their ability to teach, and their interest in and capacity for research. Of course the assistants are chosen for their demonstrated ability, and promise to do still better work. So far only five of the twelve great teaching hospitals of London—St. Bartholomews, The London, University College Hospital, St. Thomas's and the Royal Free—have been recognized by the University Grants Committee as eligible for units. To these directors of units have been appointed by the Senate of the University of London. "Units" for medicine and surgery have been organized in the first four hospitals, while the Royal Free is the first hospital in which a "unit" of obstetrics and gynecology has been established. Formerly the work in general hospitals in connection with obstetrics and gynecology has been under the care of various physicians, obstetricians, and gynecologists. The work at the Royal Free Hospital is now coordinated under the director, Professor Louise McIlroy, and her assistants who will follow the cases from the time they first come under observation.

The unit occupies the top floor of the new wing of the Royal Free Hospital and consists of an obstetrical ward of twelve beds with smaller wards for labor and isolation, etc. Adjoining it are three wards and twenty-six beds for gynecological cases with operating theater, anesthetic and preparation rooms attached. The teaching department, which is at the further end of the wing, consists of a room for examination of patients and demonstrations for students, a professor's room, and assistants' clinical laboratory. Lectures are given to the students in the main lecture room downstairs. There is also a branch connected with the hospital which is under the direction of the "unit" and which contains twenty-six obstetric beds, a few venereal obstetrical cases being included. This hospital was given by the Duchess of Marlborough, neé Vanderbilt, and is situated in convenient proximity to the hospital. It consists of small wards, furnished with taste, and is conducted on the lines of a nursing home. The patients in this department pay for their maintenance in hospital according to accommodation. It has labor wards, isolation, etc. It may be added that the department at the Royal Free Hospital is being equipped for research work upon ante-natal pathology and also upon the physiological processes connected with childbirth and pregnancy. Special researches will be made upon the economic questions in women's work, upon the influence of such on the child, the influence of venereal and other toxic diseases in pregnancy.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

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A CHRISTMAS ROSE

By EDITH LIVINGSTON SMITH, Lyndeborough, N. H.

"I WANT a set o' dishes," said black-haired Mary with emphasis, "'n a picture book, 'n a doll carriage, 'n a toy cook stove, 'n a puzzle, 'n——"

"You can't have so many things," chimed in Louise with a subdued stamp of her crutch and a look towards the head nurse's desk; "it's no fairs. Nurse said choose something you want more'n anything."

"A doll, breathed round-eyed Dorothy softly, twisting her wisp of a braid round and round her finger, "a doll with yellow curls, and brown eyes that open and shut, and shoes that button and come off."

"A watch that ticks minutes and pulses," called Sally from the third bed down.

"Seconds, you silly Sally," Louise corrected with withering superiority, "an' you can't take pulses 'cause you aint a nurse or a doctor."

"I mean 'seconds of course," Sally said blushing, "but I'm going to be a nurse when I grow up, so there now, Louise Dutton, you don't know everything."

It lacked only four days to Christmas and the girls' surgical ward in the B—— Children's Hospital was the scene of the above conversation, for the head nurse had said that she was going to make a list of names of the children that very afternoon, and would also write down the gift that each one would like to have on the Christmas tree.

Most of the children in bed were smiling with

the consciousness of a decision carefully considered, but a few were still hovering over an embarrassment of desire, while the little patients who were on crutches or in wheeled chairs went up and down the ward offering to these doubtful ones sympathetic attention and emphatic advice.

Louise, being the oldest girl in the ward, 'most eleven, had made herself mistress of ceremonies and arbiter of disputes, with an authority unquestioned by the others, for couldn't she run on crutches (when she was home), and hadn't she been in the hospital one other Christmas, two years before, and could, therefore, turn conjecture into delightful certainty.

There would be wreaths or holly bouquets for the windows. Louise had said so. There would be chicken for dinner and a Christmas tree for every ward. Louise had said so.

"You can ask for anything you want," declared Louise, "and probably, most likely, if the superintendent and the lady managers and Santa Claus have it in stock you'll get it." (Oh, tactful Louise!)

It was all very wonderful and even the nurses were excited and happy about Christmas coming so soon. At night if you weren't too sleepy and listened sharply when the swinging doors opened and shut you could hear far-away music—that was the nurses practising carols in the nurses' home, though little Rose said "maybe it was angels."

Little Rose was in the bed nearest the nurse's desk. She was sitting up with a bed rest, her cheeks as pink as her hospital jacket, her blue eyes alight with the excitement of the subject in hand.

She had hoped the others would forget about her. She hoped it hard as she pinched the bed spread into a little pattern, but Mary and Louise were swinging down her way on their crutches and Elizabeth, in the next bed, said in a voice that all could hear: "What do you want, Little Rose?"

The nurses did not know why the children called her "Little Rose," for she was seven years old and larger than some of the others in the ward. It may have been because her face was pinched and her eyes so big; it may have been because her voice was low and musical; or it may have been because she was "different" in a wistful, fragile way. It could not have been because of pity, for the children did not know why she was different. On second thoughts, though, it may have been pity, for it would seem as if intuition tells children many intangible things that wisdom cannot explain. At any rate she was "Little Rose" from the moment she had entered the ward two weeks before.

"Oh yes, what do you want?" echoed Mary.

The nurse at the desk looked up to hear the answer.

"Nothing," said Rose shyly.

"Nothing!" shrieked Elizabeth. "She can't choose nothing, can she, Miss Warren?"

"Nobody never wants nothing," announced Mary in horrified tones and horrible English.

"Choose something, Little Rose," said Louise gently. "I'll help you."

"I've chose," said Rose with a scared look at Miss Warren. "It's a secret."

"Oh dear!" wailed Elizabeth. "She can't have a *secret* about wishing for a present, cause folks won't know. That's an awful silly wish ain't' it, Miss Warren?"

"No, no," Miss Warren said with a quick glance at the thin troubled face. "Perhaps Rose doesn't want to talk about her gift now, but she'll whisper what she wants to Miss Homers when she comes, won't you honey, and then it will be all right."

But later, when the head nurse wrote down the names of the children with the "wishes" carefully recorded, she started and her pencil hovered in mid-air as Rose whispered "the secret."

"I want one dreadful, Nurse," she pleaded. "All the other children have them. The city's awful big, don't you 'spose someone could find a—a stray one for me, maybe?" Her lips trembled.

As Miss Homers did not answer, she went on in a low voice, "If I can't have that, I guess I want a baby doll. Please can I make both chooses?"

"Yes, of course, child," Miss Homers said hurriedly. "See, I have written them down."

She could think of nothing else to say.

* * *

In all the rush and excitement of Christmas preparation there was much talk of Rose's gift.

Miss Homers had hastened to the superintendent with the red book and together they sought Miss Jennings, the social worker.

"The poor little thing," said Miss Jennings.

"She is a very unusual child," said Miss Homers eagerly.

"We have never done such a thing before," said the superintendent thoughtfully, "but that is probably because we have neglected our opportunities. Between us all, with all the good friends of this hospital, it would seem as if the lady managers or some of us could find a 'stray one' as a gift for Little Rose. If you will both help me this evening we will send postscript letters by special delivery to all whom we have asked to the Christmas festivities. There isn't much time, unfortunately."

"But miracles take no time at all," said Miss

Jennings, her eyes shining, "and I love to believe in miracles at Christmas!"

This was the note, received by all the lady managers, the wives of the trustees, and other special friends of the hospital:

> "I am sending a hurried postscript to each guest who has been asked to attend the Christmas Tree festivities at the hospital to ask help in regard to one of the patients in the surgical ward. The child's name is Rose Jackson; the other children call her 'Little Rose.' She is seven years old, a lovely child with brown hair and blue eyes, an imaginative mind and a lovable personality. She is recovering from an operation for appendicitis and is otherwise healthy, except that she is thin from undernourishment. She was sent into the hospital as an emergency case by a kind neighbor who had taken her into her home after Rose's grandmother died. This neighbor has a large family of her own and Rose has no relatives as far as she knows.
>
> "As the child is homeless, she was to have been turned over to the state or some charitable institution when able to leave the hospital, but circumstances have arisen which make us feel that we should take a different course. I hope you will agree with me that it is our privilege to find a home for Rose to go to when she leaves the hospital. If any one of you knows of anyone who wishes to adopt a child this is a wonderful opportunity, and I hope such a person will communicate with me quickly. It must be a real home in every sense of the word, for the gift that Rose has asked for for Christmas is—A MOTHER."

* * *

"Oh, come all ye faithful, joyful and triumphant," sang the nurses.

Never had there been such a happy Christmas in the B—— Hospital. Never before were trees more gayly decorated or as heavily weighted with delight for childish hearts; never were sick children so merry, or ministering nurses more thankful of their calling. In all the wards supply and demand kept pace with the Christmas lists in a way which demonstrated happily that the words, for once, could be synonymous.

In the girls surgical ward the children were so excited with their gifts they did not notice that the visitors around the tree watched Little Rose with more than ordinary interest as she received a baby doll from the tree and cuddled it beside her in her wheeled chair.

Then, without words, for there seemed to be an undercurrent of understanding, the superintendent and Miss Jennings went into the sun room, followed by an eager, sweet-faced woman, and Miss Homers pushed Rose's wheeled chair into the sun room also, and shut the door.

"This is Mrs. Morrison, Rose," the superintendent said—"a friend of the hospital whom I have known a long time. She loves children very much. You remember you told Miss Homers a secret,—that you want a mother for Christmas,—and if you hadn't said that I would never have known Mrs. Morrison had a secret wish, too—she wants a little daughter. So now you will each have what you need for happiness."

* * *

"How silently, how silently, the wondrous gift is given," the nurses were singing as they started towards the medical wards, "so God imparts to human hearts the blessings of His Heaven."

The glass doors of the sun room opened and shut again, softly, and Rose and her mother were left alone.

* * *

"I wonder how many other lonely women there are in this city," Mrs. Morrison said to the superintendent as she said good-by to her a few minutes later, "who could be made happy by the promise of a Christmas Rose, and how many wistful children there are in hospitals and orphan homes who want a mother for a gift?"

"God knows, there must be many," said the superintendent.

* * *

The ward was darkened. Rose held her doll very close to her. She had begged to keep it "just this very night" and the night nurse, who knew the "miracle," as Miss Jennings called the outcome of Rose's secret, had somehow forgotten the hospital rules. Now she stooped over Rose's bed to hear what the child was saying in a sleepy voice——

"I'm going to name you after me, Dolly. I'm your mother and I'm going to have one, too. I didn't truly think I'd get any present only you, but I prayed to God for a mother and I asked the head nurse, and I wished on a star through the window. Perhaps, maybe, it was the Star of Bethlehem.

"Good-night Rose-bud. In a week we're going HOME."

THE ORGANIZATION OF THE ORTHOPEDIC SERVICE AT THE STATE UNIVERSITY OF IOWA

By ARTHUR STEINDLER, M.D., F.A.C.S., Professor of Orthopedic Surgery, and MAME ROSE PROSSER, M.A., Principal of the University Hospital School, Iowa City, Iowa

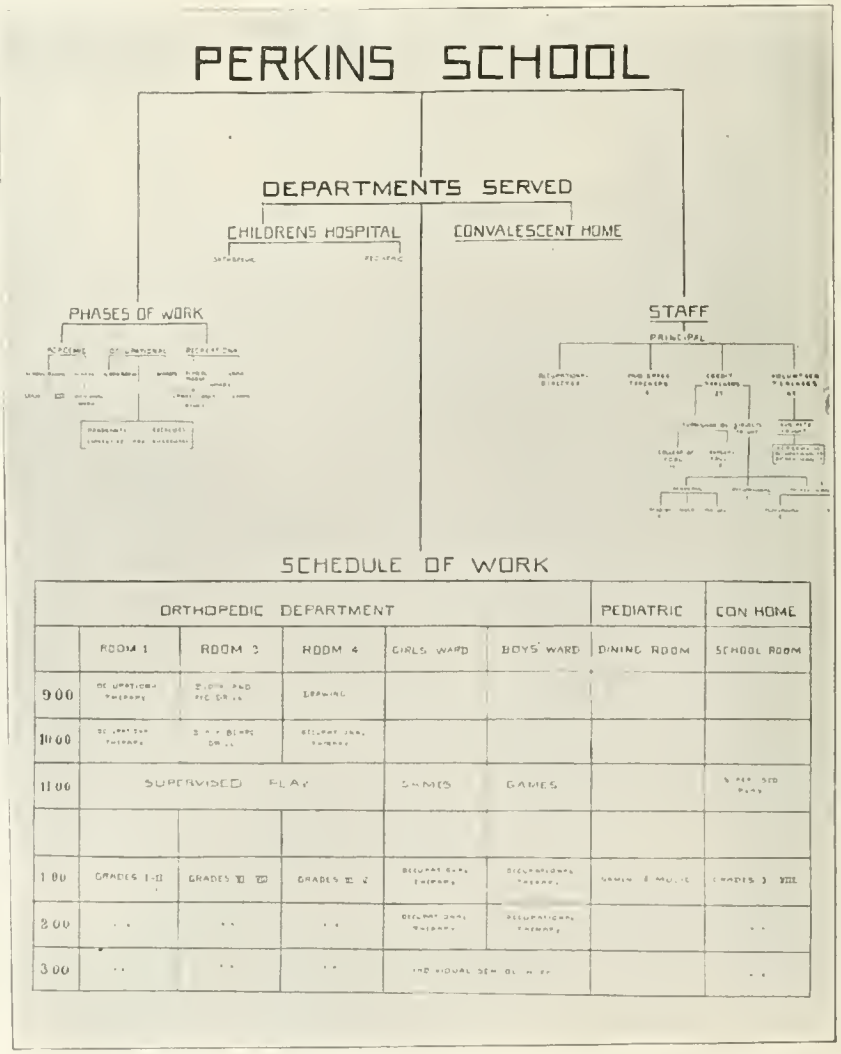
THE free medical work of the State University of Iowa is largely based upon legislation. Its foundation is the Perkins Act of 1915, amended by the Haskell-Klaus Act of 1919. These acts provide treatment and care at state expense for any resident of Iowa who is afflicted with some deformity or is suffering from some malady that can probably be remedied, provided the person or his lawful guardians are unable to provide such treatment and care. Under the provisions of these two acts about ninety per cent of the patients of the orthopedic service are admitted to the hospital.

The organization of an orthopedic center from its very nature is a matter of considerable complexity. The two great and fundamental divisions of the service are the physical and the mental, the restoration of normal physical conditions; and the development of desirable social and educational conditions. The task of organizing an orthopedic service subservient to all the needs of the patient is fraught with much difficulty and labor. In the six years of its existence the service at the University of Iowa has initiated practically all of the desirable phases involved in such an undertaking. Some branches of the work are, by force of circumstances, much less advanced than others.

The intimacy of the relationship between the physical and the mental aspects of orthopedic work varies with the stage of treatment and the nature of the disability. Both should be directed by the chief surgeon through heads of departments who have a clear idea of the ultimate result desired, and who cooperate cheerfully and intelligently to secure that result. In some phases of the work the physical result desired can be obtained without active cooperation on the part of the patient so that educational aid is not required; in other phases of the work, the educational procedure is modified but slightly by the physical condition of the patient. There are some forms of treatment, however, in which educational methods enter decidedly into the question of physical help. This is true in regard to muscle education and occupational therapy.

The physical aspect of the work at the University Hospital is provided for by the surgical staff and the nursing staff with their attendant orderlies, helpers, and nurse maids. Under the supervision of the surgical staff are the departments of mechano-therapy and occupational therapy, and the orthopedic workshop.

The educational work provided is under the supervision of the College of Education. It consists



Schedule of the organization of school and occupational work

SCENES IN THE CHILDREN'S HOSPITAL AT THE UNIVERSITY OF IOWA

Crippled children at school

A machine for every muscle—the orthopedic gymnasium, a unique feature which is run in conjunction with the orthopedic clinic.

A room of the baby ward, where pure democracy reigns. The babies do not draw race distinctions. The white and colored babies enjoy equal rights.

Studying speech defects with the aid of the dictaphone in the Child Welfare Research Station.

The milk laboratory in the Department of Pediatrics. The milk used in the children's hospital is tested every day. The laboratory diet kitchen, which is provided with a separator, a specially constructed pasteurizer, pressure cooker, sterilizer, fat tester, and other appliances. Every possible modification of milk may be obtained.

Above—a sun bath on the porch of the girls' ward. Below, at left—interior of the girls' ward in the Orthopedic Department. Below, at right—porch of the boys' ward at the recreation hour. Every face wears a smile, for the spirit of cheerfulness is all-pervading at the Children's Hospital.

Examining casts in the plaster cast room. The most interesting feature of the medical extension project at the university is the work done for children.

of the work of the first eight grades and tutoring in high school subjects where conditions warrant such work. As at present organized, the work in muscle training and occupational therapy is under the direction of the principal of the school.

Of the subdivisions of the service the orthopedic workshop, and the departments of mechanotherapy and occupational therapy, and the school work demand some detailed description.

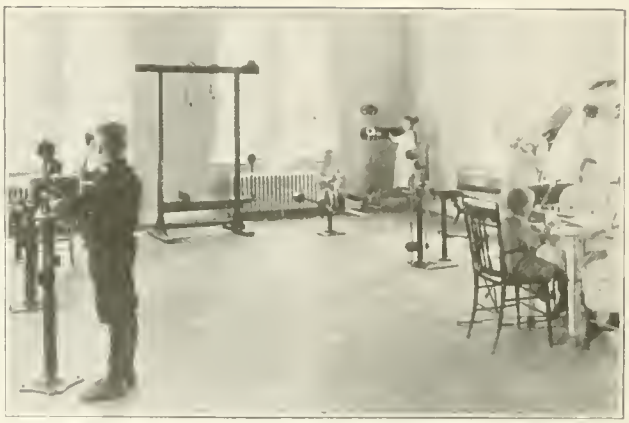
Equipment. In order to make the work of the shop fit into many of the exigencies of orthopedic work, it must be complete in its equipment even though the amount of its output is small. By this is meant that all phases of apparatus technique should be provided for—the steel work as well as the leather work, the sewing as well as the finishing, fitting, and designing. A satisfactory workshop has been planned and equipped as follows: The machinery for the steel room consists of one thirteen-inch South Bend lathe; one miller; one drill press; one throatless shears; one hand steel cutting shears; one power hammer; one blacksmith forge; one gas welding forge; two sets of polishing heads; one for steel grinding and polishing, and the other for leather polishing. This machinery is driven by two motors, one one-half and three horsepower.

The leather room is supplied with one shoemaker's jack, one leather sewing machine, and one ordinary sewing machine. In addition there are benches for leather and steel work as well as all the tools needed by the mechanic and the leather workers.

Personnel. The shop is managed by the foreman under the direction of the physician in charge and his first assistant. The foreman, who is an experienced leather worker with some experience in steel working, designs and fits all braces in accordance with directions and sketches submitted by the medical staff. Under his supervision a mechanic does the steel work with the help of an assistant. The latter divides his time between leather work and steel work. Two women helpers assist in lining, sewing, and finishing the braces.

A good mechanic is very essential for the output of well made hinges and other precision work such as automatic locks, special hinges, and the frame work of steel and leather braces. He is also employed to make specially designed surgical instruments such as chisels and files for bone work and arthroplastics.

Output. The annual output of the orthopedic shop is approximately two thousand orders which are about evenly divided between shoe and brace work. We believe that it is a distinct advantage to have experienced shoe workers employed in the shop and it is our policy to give the men who



In the gymnasium little equipment is required, for mechano-therapy is applied by the hands of experienced individuals rather than by machinery.

enter this line of work training in both orthopedic shoe work and orthopedic brace work.

One of the great problems in connection with the work has been the establishment of cost prices involving material used, deterioration of machinery, and labor. In order to come to exact figures, it is necessary to keep accurate accounts of time and material with each order put out. This is naturally a very tedious and time-consuming procedure and consequently has not been put into effect at the university orthopedic shop. But, from the approximate figures arrived at, there is reason to believe that such a shop could be conducted in state institutions as a self-supporting enterprise, with the prices for the work ranging a good deal below the commercial prices, provided that there is a thoroughly efficient management, especially in regard to the following points: (1) The purchase of leather, steel, and other material by an expert buyer; and (2) The distribution of the work in such a way that there is never an undue rush and never a slack of work. In the life of a rather active clinic, it is naturally very difficult to arrange the work in the shop so that the amount of work proceeds uniformly month after month, but it can be regulated to quite a degree by the medical staff which issues the orders for all work done in the shop. In the first place all orders should be issued by one man, the chief of staff or his assistant. Allowing a greater number of persons to issue orders is studiously to be avoided. The orders are issued on duplicate cards with the date carefully noted, and those which permit delay are dated in the future according to advice received from the foreman of the shop who knows how to distribute the work. It is the policy, however, not to allow more than two weeks to pass between the making of the model for a brace and the fitting of the brace. A certain part of the time is always kept open for emergency work which is constantly coming in from the out-patient clinic. This is mainly

shoe work, brace alterations and brace repair.

The orthopedic gymnasium is one of the fundamental institutions in orthopedic service and one upon which devolves especially the responsibility for after treatment.

Equipment. The surgeon in charge is a strong believer in the application of mechano-therapy by the hands of experienced individuals rather than by machinery. Consequently the equipment of the gymnasium has been reduced to a few types of medico-mechanical machinery, and there is a small number of Zander machines for the development of passive motion of the elbow, shoulder, wrist, knee, and ankle. The following standard forms of apparatus are also used: ladder, stall bars, pipe stalls, quarter circle, and wrist roll. In addition several smaller pieces of apparatus of our own construction are used in the measurement of the range of motion in different joints as well as for the development of certain motions of the fingers and wrists.

For the development of the gait, there is used a walking rail consisting of two long parallel bars which can be adjusted at different heights.

The Physiotherapists. The gymnasium is in charge of a first physiotherapist, a second physiotherapist, and a helper. The first two are graduates from normal schools of physical training, and the helper has been trained in this gymnasium for her part of the work. In addition to these, there are plans made to accept eight seniors from the University department of physical education into this teaching staff who will work for credit and will be assigned certain duties under the supervision of the physiotherapists.

The Patients. The average number of patients treated varies from thirty to sixty a day; the yearly number of treatments being between 8,000 and 10,000.

The Schedule. The work is conducted in classes arranged as follows:

(1) The scoliosis and posture class having two daily sittings of one hour to one and one-half hours each. For the purpose of better supervision, this class is divided into: (a) postural cases, (b) cases of incipient scoliosis, (c) class of structural scoliosis. All cases receive massage treatment individually; the corrective exercises are carried out in class.

The walking rail, consisting of two parallel bars, which can be adjusted in height, is used for the development of the gait

(2) The so-called spastic class in which cases of spastic paralysis are given treatment, massage, and exercises, having two daily sittings of one hour each.

(3) The hand classes for the mechanical treatment of deformities of hand and upper extremity. Although the patients appear in class, the supervision is practically individual; according to the needs, one-half to one hour to each patient daily. Most of the cases are referred for longer daily sittings to the class of muscle education, which is a subdivision of occupational therapy and will be discussed later.

(4) A general class consisting of the rest of the material presenting itself for medico-mechanical treatment. To this belong cases of congenital dislocation of the hip, just out of cast, static conditions such as flat feet, and other conditions.

(5) The joint class for the development of motion in afflicted joints. This work is done on no definite schedule, the larger part of it being done at the bedside.

Bedside Work. The bedside work of mechano-therapy is an important part of the work. It comprises:

(1) The general massage treatment prescribed for bed patients for improvement of general condition.

(2) Local massage of joints and muscles in cases of arthritis and other inflammatory conditions or in cases having undergone long fixation.

(3) The treatment of arthroplastics and constructive work of the upper extremity in the first phase, consisting of the application of active motion and massage.

This work is so organized that one of the physiotherapists spends part of the day at the bedside, usually two to three hours. This phase of the work is out of all routine and the cases are very strongly individualized, the treatment varying in time from a few minutes to half an hour.

The Instructional Work. It has become very necessary in the course of the treatment to pay a good deal of attention to instructing the parents as far as possible in the work of medico-mechanics in order to secure the after-treatment at home. It is impossible in this institution, where the number of patients on leave throughout the state is many times the number of patients that can be accommodated in the hospital, to discharge patients without making some provision for the

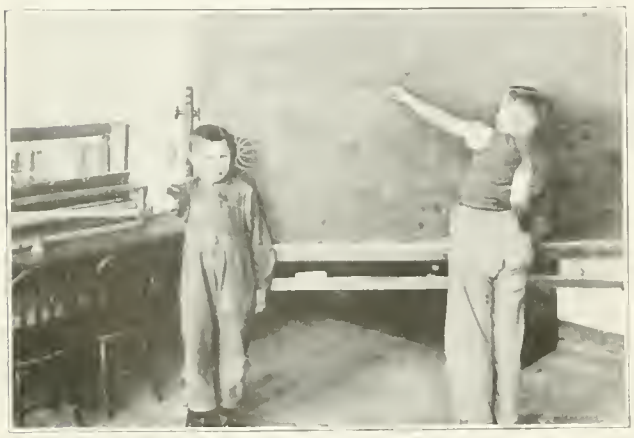
continuance of the after-treatment at home. We have found the greatest difficulty in securing such after-treatment and we had to resort to the expedient of instructing the parents as best we could. We believe in many cases that this is entirely feasible and satisfactory; the parents are required to stay in town and witness the treatment for a period varying from a few days to a few weeks. Stress is laid on explaining to them the essential phases of the treatment. As far as active and passive exercises are concerned, we have found no difficulties if the parents were intelligent and willing to learn. Application of skillful massage under these conditions is out of the question; we feel very strongly that here is a great field to be covered. Possibly the solution will lie in the education of field nurses in massage or the development of field masseuses who can be trained in institutions and sent out to continue the work. Here is a great opportunity for the public health service to branch out into the work of physiotherapy.

This department serves two distinct types of cases, those who are assigned to it for designated curative forms of work, and those for whom the value of the work lies in its recreational and educational phases.

For the first class, the work, being entirely therapeutic, is placed under the control and direction of the medical staff. The course consists of muscle education and craft work.

The second class is given craft work and gardening, and is also provided with supervised play and library service. In this branch of the work the medical staff acts as advisor only.

Teachers. At present the department of occupational therapy is directed by the principal of the hospital school. Her assistant is a graduate of the Chicago Art Institute and of the Henry B. Favill School of Occupation. This occupational therapist has had ten years of experience, two



The arm-raising rhythmic drill is performed in time to music and consists of standard blackboard exercises

Attractive lamps, baskets, flower boxes, trays and sewing stands are made in the reed and raffia work.

of which were obtained as head reconstruction aide in military hospitals. Under her direction university students from the College of Education conduct the hand work. During the past year the students have given 3,512 hours to our work and the patients have spent about four times as many hours.

We were especially fortunate in being able to secure the cooperation of the departments which provide the student teachers. Without them we should not be able to carry on the work on nearly so large a scale. The youth and enthusiasm of these teachers contribute an element of joyousness to our work, which, combined with their fidelity to the tasks assigned them, offset to a great extent their lack of experience.

The Therapeutic Cases. During the year ending July 1, 1921, eighty-nine cases of deformity of the upper extremity were treated. In the two years since the work has been organized, 123 cases have been treated. Of these, seventeen have been in the classes both years.

These eighty-nine cases devoted about seven thousand hours to strictly corrective work, and in addition over a third of them entered the general classes in supervised play.

The Corrective Work. As has been noted above, two forms of work are used: muscle training drills, and craft work.

The muscle training drills constitute the connecting link between mechano-therapy and craft work in our plan of treatment. The two drills now regularly in use are the cube and peg drill and the arm raising rhythmic drill. In both, a series of elementary motions is developed and coordinated. In the cube and peg drill the movements secured are the flexion and extension of the fingers, adduction and abduction of the thumb, flexion and extension of the wrist, adduction and abduction of the wrist, flexion and extension of the elbow, and pro-and supinatory movements.

In the wood working class many things are made, including stools, lamp bases, small furniture, book ends and toys

These movements are timed and the number of motions accomplished per minute is recorded and charted. Increased control is revealed by increased speed.

The second drill is performed in time to music furnished by a Victrola record and consists of standard blackboard exercises. It is used, for instance, after arthrodesis of the shoulder to secure the substitutionary motions required in lifting the arm. Here records of the height reached are charted.

Calisthenics involving routine exercises for the fingers, hands, and arms are used. The same motions are secured in the spontaneous activity of adapted games. In some cases shadow pictures are used. In others jack straws and jack stones, quoits and bean bags, as well as croquet, baseball, and volley ball are utilized to secure the desired end.

The first steps in craft work involve the use of wax, plasticine or clay which lend themselves readily to manipulation, or to simple weaving where complex motions are not required. As soon as possible the patient is set to work upon some project which is within his power to accomplish and which commands his interest by its use and beauty.

The types of hand work provided are outlined below:

(1) Modeling: Plasticine and permodello, plaques, toys, beads.

(2) Cement and Plaster Work: Book ends, tea tiles, plaques, and toys.

(3) Reed Work: Lamps, baskets, flower boxes, trays, sewing stands, lamp and candle shades.

(4) Cane Work: Sewing stand, stools, and trays.

(5) Raffia Work: Baskets, pillow-covers, and table-covers.

(6) Weaving: Doll hammocks, rugs, and paper weaving.

(7) Wood Carving: Tea tiles, bread boards, book ends, picture frames.

(8) Wood Work: Stools, lamp bases, small furniture, book ends, book racks, garden sticks, coat hangers, and toys.

(9) Tin Work: Candle holders and shades.

(10) Textiles: Simple hand sewing, embroidery, appliqué work, crocheting, knitting, and hooked rugs.

(11) Painting: Candy and sewing boxes, toys, coat hangers, book ends, holiday cards.

(12) Leather Work. Moccasins, purses, scissor cases, tooth-brush holders and card cases.

In addition the children have made their own decorations for Hallowe'en, Christmas, and Memorial Day as well as their own valentines, Easter cards, and May baskets.

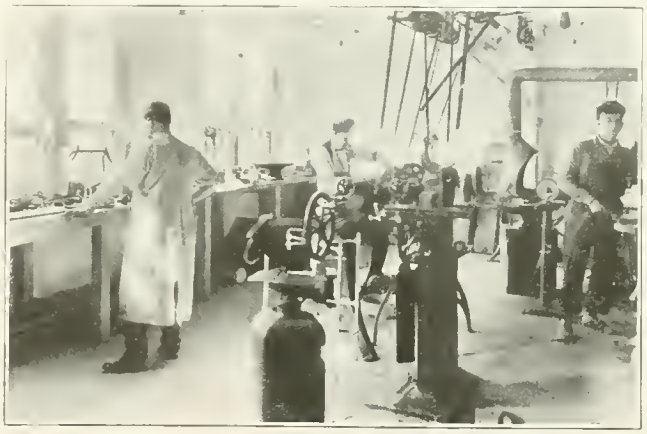
The Recreational Work. The recreational classes do the same kinds of craft work as the corrective cases; and the classes in supervised play are open to any child who is able to participate in them.

During the past year, 251 cases have been enrolled in the recreational work. They have been provided with about nine thousand hours of work and play. This does not include time spent in the garden or in reading provided by the library service.

School Work

The school work and the occupational work are scheduled by the principal of the school. All patients who are able to come to the workroom are provided with occupations or supervised play from eight to twelve. In the afternoon these cases attend school for three hours, taking up the work of the first eight grades. Bed patients are provided with occupations or tutors for school work during the afternoon hours. The teaching staff for the grade work consists of four part-time teachers who are assisted by students from the College of Education.

The total teaching force supplied by other departments to our various forms of work amounted during the past year to the services of twelve



Steel room of the orthopedic workshop.

part-time teachers working as many hours a day as these grade teachers work.

The organization of the school work is necessarily modified by the conditions under which it is carried on. Much of the work is individual in character but group work is used in so far as it is possible. We allow the greatest possible flexibility as to hours and working conditions in order to secure the best efforts of each child.

The patients served in muscle education, occupational work, and recreation are largely children. Only an occasional adult is admitted, as space is limited and the teachers are already fully occupied.

Social Service and Follow-Up Work

The social service work is directed by the extension division of the university, which sends out as follow-up worker a woman of experience whose tact and personality are of the greatest value to the institution. The peculiar situation of the hospital as a center for the orthopedic work of the entire state makes it necessary to keep three aims in view in this connection:

(1) To insure the return of the patient to the hospital upon the date set by the staff at the time of discharge. The average stay in the hospital after operation is between three and four weeks. The necessity of evacuating patients at the earliest possible date involves the question of transportation for patient and escort. Although the state bears this expense, which amounts to a considerable figure each month, it is cheaper than to maintain the patient in the hospital. The routine of discharge includes a record of the patient's condition and his needs, and a letter to his parents advising them of his condition and of the time set for his return. By a cross index card system a record is kept of the dates set, and delinquent patients are reported to the social service worker for further action.

(2) To establish sympathy and understanding between the institution and the homes from which the patients come. The information furnished the medical staff as to the social and moral surroundings, and the economic and sanitary conditions of the home is a useful guide in the discharge of patients. On the other hand, the field worker has been instrumental in interpreting the hospital to the home. There is no question that, in the early stages of the organization, when the work proceeded laboriously and with difficulty in spite of the most general help and the enlightened support of the state university administration, there were many things in which the public had to be indulgent with the growing institution. Especially was this true in regard to deficiencies in the brace work, incomplete reports, and other forms of imperfect clerical work. However, the people of the state have been, in general, extremely fair minded and most appreciative of the services rendered.

The leather and fitting room of the orthopedic workshop

(3) To secure cooperation between the hospital on the one hand and the public health nurses and the school nurses on the other hand. In view of the fact that it would be a physical impossibility for one social service worker to visit the ninety-nine counties of the state more than once a year, the institution has to depend very largely upon the cooperation of the school and public health nurses. It is the sentiment of the chief of staff that this phase of the work should be enlarged by instruction given these nurses in the after-care of orthopedic cases.

Summary

(1) The organization of orthopedic work in a center involves establishing many associated branches and is a complicated structure which can be built up only by years of strenuous and consistent work.

(2) Facilities for student and volunteer help enlarge the possibilities of service in such phases of the work as mechano-therapy, muscle education, occupational therapy, supervised play, and strictly educational work.

(3) The control of the patient through a follow-up system is greatly enhanced by complete cooperation between the social worker and the medical staff on the one hand and the social worker and the public health and school nurses on the other.

(4) The work of the Iowa State University orthopedic service is still lacking in provisions for work with adults along such lines as occupational therapy, vocational training, social and recreational life, and an employment bureau through which the handicapped may find work.*

*A state board for vocational training has recently been organized and is already doing most creditable work.

THE INDIVIDUAL ROOM HOSPITAL—THE HOSPITAL OF THE FUTURE*

By L. J. FRANK, Superintendent, Beth Israel Hospital, New York City

The advantages of the single room type of hospital, according to Mr. Frank may be classified as esthetic, therapeutic, hygienic, administrative, and economic.

Esthetically, few will question the advantages of the single room. Therapeutically, there are certain advantages surely, such as the possibility of quiet, a suitable temperature, etc. Hygienically, single rooms will tend to check contagious diseases. The administrative and economic advantages which he feels sure are there, but which might seem more questionable to others, Mr. Frank sets forth in a forceful manner. He feels that aside from questions of humaneness this type of hospital is more economical to construct and to maintain.

IF AN individual of ordinary intelligence were asked, when he was ill, whether he would prefer to be in a private room in the hospital or in a bed in the ward, he would invariably choose the private room. There must, therefore, be advantages in this private room method of treating the sick, and it is the purpose of my present paper to discuss these advantages.

In the theory underlying the planning of the individual room hospital, one must discuss three essential factors: (a) the room proper, (b) the service, and (c) the nursing.

From a practical point of view the great advantages of a room for every patient might be counterbalanced by the inadequate service arrangements and by the great work thrown upon doctors, nurses, and other hospital employees. To facilitate service and to aid the medical entourage, we have devised the individual utility room, which solves our problems.

Between every two rooms there will be a utility room which will contain all the necessities for service, including water closet, bed pan disposal, wash basin, sink, stove, cold drinking water, etc., etc., and the rooms will have all connections to make certain examinations such as x-ray, electrocardiograph, etc., and certain treatments such as Brand baths for typhoid fever, continuous baths for skin and nervous diseases, etc. We shall discuss the factor of time saving by this utility room later in the paper.

No increase in the nursing staff will be necessary; in fact, if anything, the nursing help will be reduced. As it is, for example, it is requisite to assign twenty-eight nurses to four wards of twenty-four patients each. These wards include many patients who are convalescent and need almost no attention. We plan to remove these convalescent patients to "dormitories" where one nurse at night and one or two nurses during the day will suffice for the ward. This will permit of concentrating the nurses' attention on the sick patients and will thus reduce the number of nurses in the staff.

If I were asked to classify the advantages, I would do so under the following headings: (1) Esthetic; (2) Therapeutic; (3) Hygienic; (4) Administrative; and (5) Economic.

Where does the patient of means wish to lie? Surely we construct the private pavilions for those that can afford privacy, because we see advantages in permitting a patient to recuperate in peace and quiet.

We have repeatedly affirmed that most hospitals were not built for the absolute comfort of the patient, and that in many hospitals the comfort and convenience of the attending physician were the only important considerations. Most people dislike to go to a hospital because they dread being huddled into chambers of beds where they lose their identity and become a number, resembling in this regard the convict who in the record is spoken of as number so and so, rather than John Brown, an all-important, suffering, sinning, and sinned against human being. They fear to lie in proximity to a moribund patient or to a patient suffering from a foul disease. As soon as he can at all afford it, the average patient seeks for privacy. He wants quiet and drawn shades. He wants peace, so that his nerves may be rested. The ordinary individual has a sense of modesty, a desire not to impose upon his neighbor if he can help it. He is reluctant to attend to nature's wants in public and thus, sometimes his recovery may be retarded by this natural embarrassment.

In the individual room, the patient, whether he is rich or poor, is treated as an individual, not as one of an aggregate of suffering mortals. The patient will appreciate it very much. He will be able to attend to his calls of nature without having his sense of modesty outraged, nor need he wait for his bed pan because it happens to be visiting hours or meal hours or round hours, etc. I want to stress this point with great emphasis. Comfort, contentment and quicker convalescence

*Received for publication April, 1921.

depend upon these little things. The patient will respond to such thoughtfulness, and the sensitive patient will not only feel much better, but will not be influenced by the unesthetic, disagreeable odors emitted by his neighboring sufferers.

The patient in the hospital is always under nervous strain. He worries when he sees his neighbor taken to the operating room; he worries when he sees him coming back. He is all atingle with excitement when the doctors begin crowding around one patient, when the nurses hurriedly and ominously surround a bed with the white screens. He knows that danger is threatening; he hears the shriek of the patient in agony and then the death rattle. Surely these are not conducive to recovery. In the individual room all these annoyances are obviated.

The tragedies that sometimes enact themselves in a hospital should be, as far as possible, kept away from the other patients. It has happened, in the wards, that a cheerful patient recovering from an operation is about to be discharged when an embolus suddenly sniffs out his life. The impression cannot but be depressing on the ward, but the individual room will preclude such tragic, dramatic episodes. A patient in his delirium or in a state of melancholia attempts to commit suicide. Surely, the effect on a nearby cardiac or hysterical woman is not salutary.

At night the patient has rest, real rest. He is not disturbed by the delirious, noisy patient. He is not awakened by his neighbor asking for water, or by the doctor and nurse attending to the very sick case. Nor will the patient at any time of the day be disturbed by the lights, bells, signals, and other hospital noises.

Therapeutic Advantages

Each patient has his own suitable room temperature. One patient with pneumonia may need the windows wide open, and the steam off. The next patient may need warmth and steam inhalations for his acute bronchitis. One ill man may need sweatings and hot packs for his uremia and his neighbor may need ice packs and cold air for his excessive temperature. One patient may need a stimulant and another a sedative. One cannot please all or treat all properly by one routine procedure.

The patient may need sleep and rest during the day, with quiet and drawn shades, because he is a nervous individual just entering his convalescence. Deprive him of this treatment and he may have a relapse and his recuperation may be long delayed. The next patient is a cheerful young man. He loves visitors and sunshine and he will only improve under cheerful surroundings. Surely both should receive attention according to their individual requirements. Only the individual room solves this problem.

The patient will feel that he is receiving individual attention in the private room, and in patients who are oversensitive, this psychological factor helps very much in restoring them to health.

Hygienic Advantages

It is well known that single rooms will tend to check contagion of disease. The patient coughing or sneezing will not convey his infectious germs to his neighbor. Each room is, thus, an isolation room.

Suppose the patient, while in the hospital for an operation, develops a contagious disease. The authorities need not transfer this very sick patient to a contagious disease hospital, nor need they worry about the rest of the patients in the ward. Each room is a ward unto itself, and can be washed or fumigated after the discharge of the infectious case, without the necessity of closing up the whole ward under quarantine.

Suppose a patient has a violent hemoptysis. He is not immediately rushed away from the hospital on the suspicion that he is tuberculous. No hurry is necessary. The patient is studied, and if tuberculous, and not cardiac, he is either allowed to remain, if amenable to treatment, or he is transferred in a leisurely and humane way to the proper place for his case.

"The American Hospital Association heartily endorses the progress of the War Department for the control and treatment of venereal disease, and they urge the hospitals of this country to cooperate with this program in every way, and particularly by developing or, when necessary, establishing clinics for the treatment of venereal disease and by opening wards to patients with these diseases who require bed treatment." So reads a resolution of the American Hospital Association. Surely such patients can be treated in the individual room hospital. The individual with a venereal disease requires just as humane treatment as the typhoid patient. It is not right to force a human being who has certain religious scruples to go to a municipal hospital. Syphilis is not a more vile disease than cancer or tuberculosis, and much can be done for venereal disease patients if properly treated.

Administrative Advantages

All patients may see their visitors (with the permission of the physician) every day. This is both a therapeutic advantage and an administrative advantage. Patients usually delight in having visitors, and it thus enhances their recovery. These visitors also take care of the minor wants

of the patient, thus saving the nurses labor.

The noise, the bustle of many visitors on visiting day in the wards has a very exciting effect on most patients. It is known that the expectation of visitors causes the temperature to rise and the pulse to quicken. In the private rooms, the presence of visitors is not so annoying nor does it leave any exciting impression. In the wards, the presence of a visitor at an unusual hour forebodes danger, and has a disquieting effect upon all. The patient who is used to seeing visitors at any hour does not become worried when they come at unusual times. The fact that visitors are allowed at any hour will reduce the population of the hospital at any one time, and in case of panic will not tax the exit facilities as it would if any misfortune should arise under the present system during visiting hours.

We wish to call specific attention to the fact that without an individual utility room, the private room system may not be feasible economically. With the utility room between every two rooms, I think that all such problems are solved. The time and labor of the nurse in responding to and executing a request of the patient is much saved. Without a utility room the nurse has to make the following steps in executing a patient's demand: (1) She goes to the patient and inquires what he wants; (2) Goes to get the article (bed pan, for example); (3) She goes back to the patient with the article; (4) Returns to her desk to wait until patient is through; (5) Goes to patient to get the bed pan; (6) Takes the bed pan to general utility room; (7) Goes back to her desk.

With the utility room near the patient, many of these steps are eliminated and labor and time are saved.

The rooms will be much neater and cleaner. No unnecessary individual articles will be kept in the rooms; they will all be in the individual utility room.

There will be a double system of corridors, so that serving the patient will not interfere with the passersby in the main corridor.

No separate rooms will be necessary for dying cases. This is a very great advantage from the esthetic and administrative points of view. The effect on the rest of the ward when a patient is taken away to these separate rooms is bad. They know that patients usually do not return; and they are nervous for the rest of the day. All human beings fear death, and the sick individual very much more than others. It is surely not desirable to augment this fear, and the horrible effect of the removal of the conscious dying individual to his death chamber need not be dilated upon. Surely it could be avoided.

The hospital will also be saved the necessity of having separate rooms for postoperative cases, for labor cases, etc. The individual room may many times serve as the anesthetic room with marked beneficial effect upon the patient who fears being taken to the operating room.

It has quite frequently happened that a patient in the surgical ward who came for an operation became disheartened when she saw her neighbor being prepared for the operating room, saw her brought back with the vomiting, the wretched feeling and the postoperative pain so universal in all surgical procedures. And not only was she discouraged, but often she refused the necessary operation and was discharged an invalid from the hospital.

Patients will be admitted in the order of their arrival, regardless of sex or disease. Very frequently the hospital clerk has to inform the doctor that he only has beds for males, females, or children, depending upon the state of occupancy of the various wards. A surgical patient seeking admission may be told that "We are sorry, but we have no room for surgical cases. Only beds in the medical wards are vacant now." The patient cannot choose his ailment, nor should the patients be limited to the number of beds assigned to the various medical and surgical services.

The wards will not have to be closed for painting or cleaning. Each room will be cleaned in its turn. In this way the whole hospital can be practically overhauled with very little loss of bed space.

Economic Advantages

What are the economic advantages of the individual room system? Let us first ask in what does a hospital deal? Its main business is to restore sick people to health. Anything that will tend to a quicker return of health is an economic gain. It will be seen from the other advantages pointed out that health will be attained much more promptly in the individual room than in the wards, and thus the average number of patient's days will be reduced.

Some of the reasons adduced by those who oppose the single room plan are: (1) The cost of construction would be enhanced. (2) Hospitals that are constantly under pressure have few empty beds, so the saving of maintaining empty rooms is not a fact. (3) For equal nursing service the cost of nursing will be greater. (4) The increased nursing and domestic personnel will be hard to obtain. (5) Wards from one to four beds each are amply able to meet the needs. (6) Patients not requiring constant attention will complain of lonesomeness.

The objections raised by opponents of the indi-

vidual room hospital are, it seems to me, easily answered.

(1) The cost of construction will not be increased. For, while the partitions may cost more, the height of the ceilings will be less, and thus a great saving will be made. In a ward the number of cubic feet assigned to each patient varies according to window and door exposure. In the individual room system no limitation is placed to the cubage. We must remember that we cannot huddle as many patients into a ward as we were accustomed to, if we are to have conscience and obey the spirit of the hygienic law that patients are to be kept ten feet apart. From this point of view, the partition of the ward into rooms is a great economy, and, if cost of bed construction is considered, many more beds can be had by the individual room system than by the open ward.

Unquestionably the stay of a patient in the hospital will be shortened by the individual room plan, so that the "turnover" of patients will be markedly increased and thus act as a great economic factor. This increase in "turnover" may be between 10 and 20 per cent.

To save the physicians' time, his patients—whether free or part pay or full pay, male or female, adult or child, may be grouped together, so that the time taken for rounds will be shortened.

(2) It is stated by some opponents of the plan that hospitals under pressure never have empty beds. I wish to call attention to the fact that while one ward may be overcrowded, another ward will be slow. This cannot happen in the single room system, for males and females, children, medical or surgical cases, may be placed side by side.

(3) Nursing cost will not be greater. With the utility room in close proximity to every individual room, the nursing cost will not be enhanced, as has been explained above. The fact that visitors are allowed at all hours of the day will cause a great saving in nursing labor, because the visitors will be glad to attend to the minor demands of the patients.

(4) The two-bed room system is certainly not good. One cannot have two individuals whose likes and dislikes are similar and who will sleep, eat, talk, and attend to the calls of nature simultaneously. We do not crowd a patient in his home. Even there we give him privacy and quiet.

For the out of bed patient who seeks company and who needs not to be served at his bedside there will be a "dormitory." These dormitories will be open wards, where patients who can walk to the service rooms will be accommodated. No patient will be kept here who requires service at his bedside. Thus a patient in this ward, requiring dressing or massage, etc., will go to the place where such treatment will be accorded to him. This ward will be equipped with all the accessory rooms customary for the conventional ward. For the other patients, his relatives and friends will be sufficient company, and not the aches and woes of a sick neighbor.

Dr. Flexner Favors Individual Rooms

If additional arguments are needed, I would state the following: Dr. Simon Flexner, president of the Tenth Congress of American Physicians and Surgeons, in his address[1] at Atlantic City, June 16, 1919, said that "In respiratory infections, diseases in which the inciting organism enters the body by way of the air passages, protection can only be obtained by safeguarding one person from another, that the lesson derived from the severe experience of the recent pneumonia epidemic is to the effect that such patients are not to be assembled into large groups or kept in open wards, but should be kept in separate rooms where they and their attendants may be preserved as far as possible from sputum droplet contamination."

The report on the prevention of influenza by the Committee on Public Health[2] at the meeting held at the Academy of Medicine on February 20, 1919, states that the etiology of the disease is an x factor, probably a filtrable virus disseminated by droplet infection and indirect infection through contaminated hands, eating utensils, etc.

"Infection can be prevented by guarding against coughing, sneezing, and spitting. The danger zone about the patient is four feet during ordinary and loud speaking, during coughing ten feet. To prevent infection the cubicle system in hospitals is advocated."

Patients Should Be Ten Feet Apart

According to this report, patients in open wards should be at least ten feet apart. This would mean that in the open ward which measures about seventy-one and one-half feet long, where we expect to place twenty-four patients, we should not place more than five patients on each side of the ward or ten patients in all. By placing twenty-four patients and just keeping the patients three feet apart, in accordance with the rule adopted by the New York State Board of Charities, we are keeping within the letter of the law but not within the spirit of the law. Under the separate room system, the patients will be guarded against infection, and greater accommodations will be provided within the same space. In other words, instead of the separate room scheme re-

1. Jour. A. M. A., Sept. 27, 1919.
2. Medical Record, March 29, 1919.

ducing the number of patients and increasing the cost of bed construction, it increases the number of patients and decreases the cost of bed construction, and gives each patient the necessary security against infection.

The *New York Times* in an editorial of January 13, 1919, comments on the Carson C. Peck Hospital, Brooklyn, as follows, giving us this viewpoint of the lay public on this subject: "This new hospital represents a comforting tendency in the modern treatment of the sick, a swinging toward consideration of the personal needs and wishes without sacrificing any of the authority of knowledge and trained judgment. No patient who has lived in hospitals of an only too familiar old-fashioned type can hear of a place in which he can have not only the technical services he may require, but freedom from noise, prompt attendance, hot meals, fresh pure air and sunlight, beauty of view, the pleasure of good color and well designed furnishings in his room, and, what to many will be the last word in comfort, the privacy of a cubicle inclosure if a private room is beyond his means, without feeling that this latest development of the hospital idea justifies its related word, hospitality."

WHAT DOES THE PUBLIC THINK ABOUT YOUR HOSPITAL?

By HAROLD J. SEYMOUR, Tenafly, New Jersey

ONE of the commonest disappointments to be met in hospital management is the general apathy with which the public often greets an institution's urgent appeal for funds. The board of trustees, confronted with an operating deficit, or with a need of further capital funds for adding to the physical plant, rightly reasons that the hospital is a necessary public servant, and that the public's own interests demand a prompt and generous response to the hospital's appeal. The board is puzzled to find, however, that the public is only mildly interested, and beyond a few dollars spent at a charity bazaar is perfectly willing to let the hospital get along as best it can.

The real puzzle in this situation is why the board is puzzled. One of the trustees, let us say, is a layman who owns a large department store. His merchandise is good. His service is good; the community actually needs what he has to sell. And yet, he is probably the biggest advertiser in town. Another member of the board, from the hospital staff, is a neurologist, who knows psychology backwards and forwards. He knows the great inertia of the mass mind; what a tremendous stimulus it needs in order to be stirred to action. Every member of the board is a patriotic American, of course, and during the war bought Liberty Bonds "until it hurt." What they should all remember, and apply in a small way to the problem of the hospital, is that the government spent millions of dollars in telling them why they should buy those bonds. The simple answer is that the hospital must have publicity before it can have wide support.

> *"Many hospitals make the mistake of waiting until they need the public's support before inaugurating a publicity program. They find, by doing so, that an extensive period is necessary for telling about the hospital, before anything can be told of the hospital's needs. In time, it is believed that all important hospitals, like all large universities will conduct publicity programs the year round; on the sound theory that institutions which depend on the public for support actually owe it to the public to publish what they are doing. Such an attitude toward publicity will result in prompter and more generous support. It will also tend to present hospitals in general in a different light."*

The nature of such publicity, and how it should be conducted, are questions interpreted in several ways. One interpretation, that of a large maternity hospital in New York City, is that publicity should be confined to the activities of a financial secretary whose business it is to write appealing letters to persons of means making a formal request for financial support. The chief merit of such a system is that it pays its own way, and is better than nothing at all. Another interpretation, which shall form the basis for the observations which follow, is that hospital publicity should be a campaign of education, in which the public is merely informed concerning some of the many interesting things the hospital is doing.

From Liberty Bonds to hospital funds is not such a far cry, after all. John Price Jones, former assistant director of publicity in the Liberty Loan campaigns for the Second Federal Reserve District, was one of the first to apply funda-

mental publicity principles to hospital requirements. These principles have proved themselves with many important institutions; notably in New York City with the Post-Graduate Hospital, the Broad Street Hospital, and with the fifty-seven non-municipal institutions associated in the United Hospital Fund. Any hospital, regardless of its location, can follow the same procedure with benefit.

First of all, the conservative-minded should abandon the idea that newspapers are interested only in the sensational. They are, it is true, "quack" newspapers just as there are "quack" doctors, but for the great majority of the press, as with the great majority of the medical profession, the chief aim is honest and sincere. The press aims to give a fair diagnosis and an impartial treatment of the news; to tell the public what is going on in the world, and thus to serve as an instrument of education.

From this point of view, the first requirement of hospital publicity should be to tell the public something the public ought to know; to educate the public on matters of public health. It is not enough to make a formal announcement that the hospital needs money. The public must be shown that the hospital deserves it. To do this the hospital must tell its story.

What shall the story be?

He who prepares the publicity must satisfy two laws; one, the law of medical ethics, and the other, the law of supply and demand. He cannot violate the physician's ancient code, which abhors "cures," and he cannot violate the newspaper's code, which abhors that which is distasteful to the lay mind.

A new technique in the application of radium, holding out new hope for the successful treatment of cancer, would make a splendid news story, with an educational value; but the ethics of the code requires that the technique should first be discussed in medical journals. On the other hand, the head of a genito-urinary department once spent a whole morning with me, explaining some of the interesting things the department was doing, and then could not understand why the story would not be of interest to the newspapers.

The things about a hospital which make interesting stories, and which would be perfectly apparent to any good reporter, lie in the dispensary, in certain activities of the medical and surgical services, in certain special departments, and in the details of administration, as follows:

I. The Dispensary.

Perhaps the nearest thing to the public in this department is the social service work. For that reason it is one of the most fertile fields for publicity. The average social service worker has a vast fund of the very sort of "human interest" stories that a city editor is always looking for.

Other stories, things which the public will be interested in, will be found in the cardiac clinic, the diet clinic, and the clinics or anaphylaxis and mental deficiency. How many people know that a pain in the region of the heart rarely indicates heart troubles? How many parents realize that malnutrition is not necessarily an affliction of the poor? How many sufferers from asthma realize that their spasms may be due to sleeping on a feather pillow? How many people understand the relation between mental deficiency and juvenile delinquency? These are things which the public ought to know, and would like to read about. And in reading, the public will realize that this particular hospital is doing something well worth while.

II. Medical Service.

One of the most interesting questions to any man is the probable length of his life span. The duration of life and the extension of the life span, were close to man's thoughts long before the days of Ponce de Leon and his fruitless search for the fabled fountain. In a hospital, longevity is usually expressed in terms of the degenerative diseases. These are the province of the medical staff, and there is always room in a newspaper for an authoritative discussion of cancer, arterial sclerosis, or the diseases of the kidney.

III. Surgical Service.

Probably of greatest publicity value in this field are traumatic surgery, orthopedic surgery, and surgery of the brain. As a rule, however, it is in this department that successful publicity will be most difficult; the professional code ruling out discussions of rare cases and new technique.

IV. Special Services.

In this field are classified the laboratory, radium therapy, the x-ray, mechano-therapy, unusual diagnostic instruments used in cardiac and neurological work, and the diet kitchens. What is the laboratory doing toward solving the secrets of the suprarenal? What is the hospital doing, or planning to do, with radium? How do the neurologists chart emotional reactions? How much does it cost per day to feed a healthy man on a scientific, well balanced diet?

V. Administration.

At first thought, there would seem to be little material of public interest in the dull routine of hospital administration. But there are dozens of brief and interesting statistical stories to be found on the purchasing agent's cost sheets, on the service records usually tucked away in a table in the annual report, and in the records of ambulance runs. The training school for nurses has its news just as any school has. If it costs more

to run the hospital today than it did last year, say so, and tell why. If unemployment has resulted in an increase in the number of free patients, or if the housing shortage has made it necessary for many persons to come to the hospital for ailments formerly treated at home, let the public know about it, it's *news*.

Tie Up Hospital News and Current Events

These are the apparent sources of publicity material; the things which are essentially of the hospital. But there are also other sources, into which the hospital can project itself merely by keeping in step with current events. This involves "tying up" the hospital's news with the news of the day, offering comment by hospital authorities on pathological crime, epidemics, important medical discoveries or developments elsewhere, or a succession of similar accidents in the city. There are seasonal "tie-ups" also, dealing with sunburn, heat prostration, colds, frostbite, cold exhaustion, and special diets to suit the season. Furthermore, there are opportunities to be gained merely by watching the calendar; by noting precautions against tetanus on the Glorious Fourth, by telling how the hospital observes holidays, and what the social service department does at Thanksgiving. Miscellaneous "tie-ups" are to be numbered only by the publicity man's capacity for originality.

The relative value of different kinds of hospital publicity can be analyzed by the varying effects on the reader. There are two appeals: emotional, and intellectual.

The emotional appeal is the stronger of the two; involving the appeal to the reader's self-interest, and to his sympathy. Nothing has such an immediate reaction as the story which applies most directly to the reader himself, and the more readers to whom the story has a direct application the greater the value of the story. For example, a story about a cure for burns by the x-rays has a certain appeal, but there is a much stronger appeal in a story about sunburns; for the simple reason that more people get burned by the sun than by the x-ray. For the same reason, people are apt to be more interested in life extension than in infant mortality.

Don't Tax Sympathy Too Far

After the appeal to selfish interest, the strongest is that which arouses sympathy. The "human interest" story is always welcome; with the reservation that every cloud must have a silver lining. There must be a smile tucked away somewhere in every good "sob" story.

The intellectual appeal is scientific or institutional; dealing either with news of some advance in medical science, or with news about what the hospital is doing as an institution.

Just a word about mechanical details:

The best method of distributing publicity material to the press, oddly enough, is not to distribute it at all. The ideal method is to call up the papers, ask for the city editor, and tell him what the story is. If it is good enough, and he has a spare reporter, he will undoubtedly send a man to cover the story. But ideal methods are not always possible. Therefore, if a story is to be written at the hospital, the essential requirements are that it should be typewritten, double-space, should give ample authority for all important statements, and should by all means be brief. If the story is to be sent to more than one paper, it is customary to make a notation at the top of the first page, telling at what time the story can be made public.

Hospital Photographs Usually Poor

Hospital photographs are usually so unsatisfactory that a word about them here may be worth while. Experience has shown that the pictorial possibilities in a hospital, from a publicity point of view, can be adequately summed up in three classes—smiling babies, attractive nurses, and intricate apparatus. The rules to be observed in having pictures taken, if they are to be submitted for publication, are to keep the subject looking cheerful, to have the persons in the picture doing something—not looking at the camera, and to avoid picturing apparatus by itself. Someone should be standing near the apparatus, doing something with it. Following these rules, arbitrary though they seem, will save a hospital many dollars in photographers' fees.

Many hospitals make the mistake of waiting until they need the public's support before inaugurating a publicity program. They find, by doing so, that an extensive period is necessary for telling about the hospital before anything can be told of the hospital's needs. In time, it is believed that all important hospitals, like all large universities, will conduct publicity programs the year round; on the sound theory that institutions which depend on the public for support actually owe it to the public to publish what they are doing.

Such an attitude toward publicity will result in prompter and more generous support. It will also tend to present hospitals in general in a different light. Instead of regarding a hospital symbolically, as a place to go when you get sick, the public will take the preferable attitude that a hospital is a place in which to get well. Any hospital manager can take a lesson from the clergyman who advertised his church as a "Cheerful Church." Publicity can make hospitals "Houses of Health."

THE EDWARD HINES JR. HOSPITAL

By JOSEPH J. WEBER, Managing Editor, The Modern Hospital, Chicago, Ill.

THE construction of what is now the Edward Hines Jr. Hospital, (hitherto popularly known as the Speedway Hospital) was begun by Mr. Edward Hines by direction of officials of the war department when the world war was at its height. Our soldiers had been participating in some of the heaviest fighting, and in the fall of 1918 transports were bringing literally thousands of sick and wounded back to the United States for care and treatment. Hospital beds and yet more hospital beds, was one of the crying needs of the hour. The opportunity to secure by Christmas of 1918 a 2,500 bed hospital at the Speedway, for $1,000 a bed, was therefore eagerly seized by the army authorities. Work was begun in the early fall, and by Armistice Day one quarter of the hospital had been constructed. Since then various obstacles, which need not be enumerated here, have interfered with the completion of the hospital. Now, however, it is being completed and turned over by the contractors to the United States Public Health Service for equipment and operation.

The hospital, which is located at Broadview, Ill., just beyond Chicago's city line, consists at present of six buildings, constructed of brick with stone trimmings: the hospital proper and five smaller structures—an administration building, a power house, a subsistence building, a combination garage, mortuary and chapel, and the residence of the commanding officer. A recreation building is now under construction. The most remarkable thing about the main building of the hospital is its length, which is 2,040 feet—two fifths of a mile. Probably the next most remarkable feature of the hospital is the fact that it is located at the extreme western side of a 320 acre plot of ground, formerly known as the Speedway—a motor racing track. The shape and location of this building were determined by the absurd notion that its construction could be facilitated during the winter months if it were built under the then existing steel-canopied grandstand of the race track.

The building, which runs north and south, is divided for administrative purposes into seven units, or divisions, lettered A, B, C, D, E, F and G, beginning at the southern end. Each of these units may be to a large degree regarded as a hospital in itself, for each unit occupied by patients is in charge of a medical officer who is responsible to the commanding officer of the entire institution for what goes on in his unit.

The building, as originally planned, was to be devoted wholly to the care and treatment of patients. Congress, however, has refused to appropriate funds for the construction of living quarters for the medical staff, the nurses, and the lay help; consequently it has been necessary to set aside and remodel two units and a part of a third unit for this purpose. This practically leaves but four whole units for the care and treatment of patients, i.e., units A, B, C and D. Under the present arrangement unit A, at the extreme southern end of the building is used for cases of tuberculosis, unit B for surgical cases, unit C for medical cases and unit D for psychiatric cases.

Except for the operating suite and a few other rooms, the floors of the main building, corridors, wards and rooms, are concrete throughout. Recently it has been decided to lay strips of battleship linoleum down the center corridor and in the solariums at either end of the building.

The walls are painted brown to a height of five feet, and from there up a French gray. The various floors are served by seven passenger and four service elevators, and opposite each of the passenger elevators is a wide concrete stairway.

The Edward Hines Jr. Hospital is two-fifths of a mile long.

The buildings are heated throughout by steam, and ventilated by the natural draft open air type of ventilating system.

The water supply is at present received from the town of Maywood, but two artesian wells, which it is expected will give the hospital an ample supply of good water, are now being driven on the grounds.

Such is the construction of the building that all of the rooms are outside rooms. The spacious windows—in many instances French windows which, with their transoms, extend from the floor to the ceiling, insure abundance of light and air. At night the indirect lighting system makes the hospital very restful.

A modern automatic electric call system, with light, call and release adjustments places the personnel of the hospital within easy reach of every patient.

Although the building is of fireproof construction and contains little material that would burn readily, it is equipped with a modern fire alarm system as well as fire escapes. The institution has three main kitchens, all of which are on the fourth floor. They are spacious, well ventilated and equipped with modern labor-saving devices.

As already indicated, unit A, at the extreme southern end of the building, is devoted to the treatment of tuberculous patients. This section is subdivided into many small rooms, especially adapted for caring for sufferers of this disease. These various rooms and wards are amply provided with baths, showers, and toilet accessories, there being washstands in nearly all of the small rooms or wards. On each floor of this unit are ample solariums which, as the hospital runs north and south, receive the full benefit of the morning and afternoon sun. The picture of one of these solariums is published with this article. Each

One of the larger wards.

floor is provided with a large and well equipped diet kitchen, there also being a general dining room on the fourth floor for the use of ambulatory cases. Each section is provided with elevator service, so that the minimum of exertion is required of patients of this class in going to and from their meals. This unit has its own operating room on the fourth floor. It is also provided with a separate laundry, so that none of the linen goes to the general laundry.

Unit B is devoted entirely to surgical work. On the fourth floor of this unit is located the principal operating suite. It consists of one main and several smaller operating rooms, and the customary accessory rooms, such as anesthetising room, sterilizing room, nurses' workroom, surgeon's wash-up and locker rooms, and nurses' wash-up and locker rooms. The department has its own connecting corridor, with attractive built-in closets for surgical instruments and nursing accessories, as well as blanket warmers. The floor of the operating rooms is a six inch light gray tile, which is carried up the walls to a height

Individual units of the hospital are admirably equipped. This picture shows the clinical room of the dental suite. The chairs and cabinets are finished in mahogany.

A corner of the main laboratory.

of about five feet. The latter are also painted a light gray enamel, which gives the rooms a pleasant, restful light, a welcome departure from the glaring whiteness of many of the operating rooms constructed during the past two or three decades. Daylight is admitted from the west, north light being out of the question, since the main axis of the building runs north and south. For night work, and accessory lighting on dark days, the operating rooms are equipped with twelve overhead lights with x-ray reflectors and an auxiliary of four gas lamps. This unit also contains a nine room eye, ear, nose and throat suite, fully equipped with every modern device for examination and treatment. There are two recovery wards—one connected with this suite and the other across the corridor. The arrangement and technical equipment of this department will be described in an early issue of THE MODERN HOSPITAL. The dental department, located just across from the main operating suite, contains, in addition to the main clinic room, an extracting room, a dental laboratory and the office of the dental surgeon. The clinic is equipped with seven mahogany-finished Ritter chairs and cabinets with glass trays. Bosworth nitrogen lamps, suspended from the ceiling, are used for operating light. The x-ray department, with its rooms for taking x-ray pictures, fluoroscopic examination, and the development, examination and filing of plates, is admirably arranged, and contains a number of features not commonly found in x-ray departments, such as, for example, the beveled window setting, which gives the operator in the control room a wide range of vision into the x-ray room. The surgical unit also has a well equipped plaster room for its orthopedic cases. All appliances used in this department will be manufactured in the hospital's own orthopedic shop, which is equipped with suitable lathes and other facilities for this work.

The solariums at the southern end of the building are used as open wards for tuberculous patients.

Section C is devoted to the care of general medical cases and in construction is practically similar to that described in A. This section is subdivided into many small wards and individual rooms, a distinct advantage in the treatment and care of the various classes of medical cases.

Section D is set aside for the neuropsychiatric cases. All of the windows in this section have screens of the latest approved type which are protective but at the same time do not offend the sensibilities of the patients. This section is amply provided with all forms of hydrotherapeutic and electrotherapeutic apparatus which is now considered so important in treating this class of patients. The rooms devoted to hydrotherapy contain, besides the continuous-flow bath tubs with anti-scalding valves, arm and leg baths, needle and shower baths, perineal douche, seat bath with wave spray, a pack sink and the Barnet type of control table. In this department there is also a tile-lined swimming pool of moderate size. On the first floor of unit F there is a room devoted to occupational therapy for ambulant patients.

The administration building is two stories high, and is located back of the center of the main building, i. e., directly behind unit D.

On the east side of the lobby is the information desk and telephone switchboard. On either side of this lobby are the admitting department, with a waiting room and several examination rooms, an emergency treatment room located near the ambulance entrance, a reception room, registrar's office, the offices of the director of social service, the compensation office, the post office, and the stationery supply room. The second floor contains the offices of the commanding officers, the executive officer and his assistant, the chiefs of the medical and surgical services, the chief nurse, the chief dietitian and the chief clerk, in addition to the staff conference room, the medical library and the office of the personnel and materiel officers.

The subsistence building is also a two story building, the second story of which is devoted wholly to storerooms of various sizes. The first floor contains, in addition to several storerooms, a large refrigerator, the meat receiving and dispensing rooms, the bakery, which is equipped with gas ovens, and the ice-making plant, which has a capacity of eight tons, and which supplies refrigeration for the subsistence building and ice for the institution as a whole. A railroad siding leads to the unloading platform of this building. In this connection it should be said that a number of small refrigerating plants using sulphur dioxide are located in the garret of the main building and supply the refrigerators of the three main kitchens as well as those of the diet kitchens on the various floors of each unit.

The laundry equipment consists of Troy installation of three forty-two-inch by eighty-four-inch Trojan washers, one forty-two-inch by ninety-inch dry room tumbler, three thirty-inch solid curb extractors, one twenty-five-gallon starch cooker and one Big Eight F. W. ironer, electrically operated by remote control board; also four Prosperity garment pressers, ironing boards, etc.

The hydrotherapeutic room is well equipped to serve its purpose.

The power house contains eight fire tube high pressure boilers of approximately 190 horsepower, each supplying steam for low pressure gravity return heating system; also supplying high pressure steam for kitchens, sterilizers, blanket warmers, etc.

The fourth building houses the garage, which has a capacity of fourteen cars; the mortuary, with nine compartments; the autopsy room; and a small chapel, having a seating capacity of about fifty.

In front of the main building, a short distance to the east, is the residence of the commanding officer. This is also built of brick and conforms to the general architectural style of the group.

Such is the magnitude of this hospital that it

One of the three main kitchens located on the top floor.

is impossible in an article of this length to do more than sketch its main outlines. In closing, however, it seems appropriate to say that, while the hospital has a number of admirable features, there are a number of others whose appropriateness and wisdom might well be seriously questioned. Take the floors, for example, why are they made of concrete, particularly those in the wards and rooms? Why is not the main laboratory located in a series of small rooms instead of in an extraordinarily large room, and arrangement which makes classification of the various functions of the laboratory next to impossible, and hampers scientific work? Should not provision have been made in the hospital for a central pharmacy? There is no diet kitchen for the preparation of special diets. Why was this omitted? Could there be a more unhappy arrangement than that of locating the chapel opposite the autopsy room, with their doors facing each other? Why does not Congress provide funds for the housing of the doctors, nurses and lay help, instead of allowing one-third of the main building, which was designed specifically for the care and treatment of the sick, to be used for this purpose? These are but a few of the questions that will occur to any visitor who is at all informed on hospital construction and administration. Their number could easily be increased.

SURVEY OF NEW YORK HOSPITALS FURNISHES FUND OF VALUABLE DATA

Valuable statistical material concerning hospital problems will shortly be available for the use of general, special and proprietary hospitals from the findings of the Public Health Committee of the New York Academy of Medicine which is making an intensive and extensive survey of hospitals in New York City. Dr. E. H. Lewinski-Corwin, executive secretary of the committee, reports that the field work of the survey is now drawing to a close and that much of the tabulation is completed.

Data on 181 institutions in the city have been collected. Intensive work has been done on medical organization, the analysis of medical records, social work in connection with the problem of convalescence, the nursing situation, hospital records and reports, cost and several other problems.

On the extensive side, says Dr. Lewinski-Corwin, the committee has gathered complete information on the existing facilities by services, by charges, distribution of patients, seasonal variations and utilization of bed capacity and the methods of admission, charges for laboratory, x-ray, operating and other services for private, semi-private and ward patients.

The study also deals with the income and expenditures of all the hospitals, with the free and paid work and with the valuation of hospital properties, subdivided by grounds, buildings and equipment whenever the latter can be obtained feasibly. Items of maintenance have been subdivided into component parts and percentages figured for each item in every type of institution. Exact information has been obtained as to the various types of employees and the ratios worked out for each group of hospitals.

Attempts are being made by the committee to learn the size of waiting lists and statistics of rejection whenever feasible so that the adequacy of distribution of hospital facilities and the extent to which the existing facilities meet the demand may be determined.

The problem of convalescence and provision for the chronically ill constitutes another phase of the survey and coupled with it was made a study of medico-, thermo-, electro-, hydro-, and occupational therapy. A survey has also been made of the problem of workmen's compensation in connection with hospitals.

Methods of conducting the hospital survey are the same as those developed by the committee in its dispensary study of last year.

REQUESTS OFFICIAL USE OF AFFILIATION

To aid in the future development of the American Hospital Association, that organization has sent out requests to its institutional members to use the words "Member of the American Hospital Association" on their annual reports and other formal papers. The Association asks that this practice be established pending the development of an official insignia.

Dr. A. R. Warner, executive secretary of the Association, in making this request of hospital members, says:

"This practice will create stability, extend interest in the Association, and make it mean something to each of your communities. All this in turn means greater opportunities to the Association to serve and a stronger incentive to work for the development of the field. The first time there must be explanations to your trustees and to others; then it will be routine and explain itself, but continue to produce results.

"Institutional membership in the Association now means that these hospitals are not only seeking all possible ideas and aid for bettering their local work but are actively interested and contributing to the development of the entire field. They in fact form the front line of those who are pushing progress in hospital work. That is the reason they become members."

HOTEL-HOSPITAL FOR CHICAGO

Construction of a fourteen-story, 500-room hotel-hospital in Chicago, at the estimated cost of $2,500,000, is being started this month. The hospital, to be called the Franmore, will be erected at Jackson Boulevard and Wood street in the heart of the city's great medical center. Seventeen medical institutions in that district with their 2,677 beds will be served by the new structure.

The hotel-hospital will accommodate ambulatory patients who need diagnostic facilities of the nearby hospitals, patients awaiting admission to hospitals, discharged convalescents who still need medical observation, relatives of patients at the various institutions nearby, and out of town physicians who are attending special clinics or professional gatherings. The building is expected to relieve congested conditions at hospitals in the city. A small amphitheater will accommodate medical societies, clinics and other professional gatherings.

For 20 years the erection of such a building has been discussed but plans did not take definite shape until late October. The hotel will open about October 1, 1922. Berlin, Swern & Randall of Chicago are the architects.

The noblest motive is the public good.—Virgil.

LABORATORY SERVICE IN HOSPITALS OF LESS THAN ONE HUNDRED BEDS*

By G. F. STRONG, M.D., Assistant Superintendent of the Vancouver General Hospital, Vancouver, B. C.

The cost of equipping and maintaining a laboratory in connection with the small isolated hospital is thought in many cases to be prohibitive. Consequently such institutions are denied that laboratory service which is so valuable an aid to correct diagnosis. Dr. Strong of one of the largest hospitals in Canada has prepared a list of laboratory equipment for the small hospital which allows a wide field of service at a low cost and he believes that the installation of such equipment for ordinary examinations, combined with a system of cooperation between small institutions and large central laboratories in the execution of the complicated tests, will help to solve this great difficulty.

IN THE past few years the hospitals of our continent have been most thoroughly impressed with the importance of laboratory work, and recognizing this and the many difficulties connected with carrying out the service, I have been prompted to present this brief paper, designed to set forth in as practical a manner as possible the essential minimum laboratory service which should be found in every hospital caring for the sick. It presupposes cooperation between the large and small hospital laboratories, especially in relation to the training of technicians and the performing of certain complicated technique which cannot be carried out in the smaller laboratory.

The laboratory service probably represents our most efficient aid in proper diagnosis, and includes besides the Clinical Laboratory—the X-Ray, the Electrocardiograph, the Respiration Calorimeter and other such instruments. I shall consider only the Clinical Laboratory and shall outline the requirements of such in a hospital of less than 100 beds. I will try to set forth the fundamental and minimum service which every hospital should give. Larger hospitals should have a much more highly organized laboratory department than that which I am describing.

The object of any laboratory service is, of course, to aid directly in making or confirming a proper diagnosis, thus so guiding the treatment that the patient may be returned to health in the shortest possible time and in the best possible condition to be of use in the community.

There are certain essential requirements that any laboratory must fulfil. Its work must be accurate, the clinicians must be able to depend absolutely on the laboratory reports. It must be so organized and maintained that it can report its findings promptly. The service must be accessible to all. The laboratory depends for its existence on the intelligent use of its facilities by the clinicians. Such use can only come when the clinicians are well acquainted, not only with the laboratory procedures and their constant improvements, but with the technicians who are carrying out these procedures. Close cooperation, therefore, is to the advantage of all.

The laboratory must be equipped to examine urine. The examination must include the determination of specific gravity and the reaction, the tests for albumin and sugar and the microscopical examination of the sediment. Specific gravity is especially important in certain forms of chronic nephritis in which this factor tends to become fixed. Albumin is most commonly found in the nephritides, also it is especially important as an early indication of renal trouble in pregnancy. It is sometimes necessary to determine the amount of albumin excreted. This can be done with a sample from a 24-hour specimen. Sugar is present in a number of conditions. Its continued presence in the urine is usually diagnostic of diabetes mellitus. In some conditions it is desirable to know the amount of sugar excreted each day and this is easily determined.

The nature of the sediment, as determined by microscopical examination, is very helpful in diagnosing acute infections of the kidneys, ureters, and bladder, and the chronic nephritides. The examination of the sediment for tubercle bacilli is the only positive test for tuberculosis of the kidney. Sediment for examination is best collected by centrifuging a freshly voided specimen. It may be obtained by allowing the urine to stand for some time, but the centrifuge offers a much quicker and more certain means of collecting all the sediment. There are many cheap and efficient centrifuges on the market; some run by water power, others by electricity, and others by hand. Of the other than routine tests, the most important is the test for diacetic acid. This substance is important when it can be taken as a

*Reprint from the proceedings of the British Columbia Hospital Association convention held at Kamloops, B. C., in July, 1921.

sign of acidosis and, in the treatment of diabetes mellitus, it is quite essential that it be tested for daily. Another test that might be demanded in certain cases is the test for bile. Though this is by no means as simple as the previously named test, it may be done in the small laboratory and the results will occasionally justify the effort.

I do not believe that the other more complicated urine tests, such as the one for urea, diastase, total nitrogen, etc., should be attempted. There are very few cases in which these tests are absolutely necessary for a diagnosis, and in such an event the cases had better be sent to the more fully equipped laboratory center.

There are the functional renal tests, however, which must not be overlooked. The phenolsulphonephthalein test is the most important simple test we have to give us an accurate idea of renal function. The technique is extremely simple and the result very valuable. Another functional test that is extremely useful is the Mosenthal test or a modification of it. For the small hospital the simpler technique of the so-called two-hourly test is more apt to be properly carried out and is quite as valuable in its results.

Blood Examination

The first requisite for a blood examination is a technician who can count blood corpuscles with accuracy. The degree of error of such count must not exceed four per cent. Such proficiency can only be attained by practice; for this reason, a non-medical technician who is able and willing to spend a great deal of time at this work is superior to a physician. Next, it is necessary to have a properly standardized hemocytometer and a reliable miscroscope. The most important test in the majority of cases, is a white and differential count. This is essential in acute surgical conditions, especially those involving the abdomen. The red count and the examination of the red cells in a blood smear to determine any abnormalities of morphology and to detect the presence of any abnormal red cells, is of importance in the anaemiaes, as is also the estimation of the hemoglobin contents of the blood. This latter determination is done in many ways. The simplest, and perhaps the best method for small laboratories, is the so-called Tallquist method which is also the cheapest means available. For more accurate results, especially in low hemoglobin findings, a more accurate apparatus must be used, such as the Sahli Hemoglobinometer. A complete blood count, consisting of a red and white count, a differential, an examination of the morphology of the red cells and a determination of the hemoglobin, might be well done as a routine on medical cases. Where time for such a complete examination is not available the following procedure is helpful:—It has been found that for practical purposes, if the hemoglobin is above 75 per cent, and if the case is not one of anaemia of some form, the red blood cells will always be within normal limits. Also it has been found that in non-acute conditions, if the white cell count is within normal limits, a differential is not necessary. Thus, in many cases, a practically complete blood examination may be performed by determining the hemoglobin and the white cell count. A blood count, when not an aid in making a positive diagnosis, is helpful in ruling out certain diseases. The examination of blood smears for parasites is essential, especially in districts where malaria is encountered.

Blood cultures should not be attempted because proper incubating facilities cannot be installed owing to the relatively large expense. By "relative expense" I mean that in considering laboratory equipment we must consider the use that will be required of such equipment. For example: An incubator can be obtained at less cost than a miscroscope but a microscope is absolutely essential and will be used at least once for every hospital case, whereas an incubator might not be needed except for one case in ten. An incubator, then, is relatively more expensive than a microscope. Serological work, including Wassermann tests, Widals, etc., should be handled in the large divisional laboratories. Blood chemistry is also somewhat too complex to be attempted without a skilled technician specially trained in this work; besides, the apparatus required is too expensive for the small hospital.

Bacteriological Examinations

For the bacteriological work there must be facilities for the examination, microscopically, of sputum and discharges of various kinds. Further than this the small hospital should not attempt to go, as it involves the expense of proper media and incubators. There should be the necessary stains for examining smears for tubercle bacilli, gonococci and the organisms of Vincent's angina.

Pathological Examinations

The pathological work cannot be done in the small hospital on an adequate scale. The surgical pathology should by no means be neglected on this account. Tissue removed at operation on which a pathological diagnosis is required, can be sent to larger institutions for a report by the pathologist. The tissue so sent, if large and thick, should be cut serially into thin slices so that it will be well hardened. If small, as appendices, etc., it should be left intact. This material should

be sealed in a small bottle containing a preserving and fixing solution and mailed promptly to the central laboratory. The cost of this service should be met by some flat rate based on the bed capacity of the small hospital.

Spinal Fluid Examinations

A laboratory of any size must be able to examine spinal fluid—a cell count and the determination of the globulin are the important tests. The Wassermann on the spinal fluid should be done, with the rest of the serological work, in the central laboratory. The cell count is performed by means of the hemocytometer used in blood counting, with the difference in the degree of dilution used. An increased count always indicates inflammation of some kind. In the acute forms of meningitis there is a high count of mostly polymorphonuclear cells; in the chronic forms, tuberculous and syphilitic, there is usually a lower count and the predominating type of cells is the mononuclear. In syphilis of the brain and cord, as well as in syphilitic meningitis, there is an increased cell count. Globulin also usually means inflammation.

Examination of Stomach Contents

The examination of the stomach contents after a test meal, is frequently very important and should be done more often. The use of this simple test will sometimes obviate the necessity of an x-ray examination, thus saving the patient time and money. This is specially to be remembered in those institutions without an x-ray outfit. The routine examination of stomach contents collected one hour after an Ewald or similar test meal, consists of the determination of the degree of digestion as judged from microscopic appearance; the estimation of the amount of free hydrochloric acid, of the total acidity, of the presence of lactic acid and of occult blood, and the Boas-Oppler bacilli. These tests are quite easily done and do not require technical skill nor elaborate equipment. The results are valuable, not only in gastric disease, but in general disease with some secondary functional or organic gastric disorder.

Examination of Feces

The examination of feces is so simple as to require a mere mention, and yet it is an invaluable diagnostic aid. The examination should be both macroscopic and microscopic in the search for parasites or their ova. Occult blood may be important in chronic intestinal cases. The presence of unusually large amounts of fat points to some disturbance of the external secretion of the pancreas.

This completes the list of laboratory examinations that may properly be made in the smaller hospital. I have outlined these tests only very briefly, as it has been my intention merely to suggest the possibilities and limitations of the small laboratory rather than discuss laboratory technique. Any small text on laboratory methods will give in detail the above mentioned tests.

The small hospital laboratory becomes, then, in a sense, an outlying branch of the large laboratory. The smaller laboratory, as it grows in volume of work, would be able to take more and more of the necessary procedures unto itself, thus finally becoming an independent unit with a complete staff. The plan of large central laboratories cooperating with the smaller hospitals in the execution of the complicated tests, offers a solution to the problem of furnishing proper means for correct diagnosis in the small isolated hospitals. This whole scheme, of course, applies principally to the small hospital in the small city, town and district, where a larger bed capacity is impossible and where facilities should be afforded the clinicians for good work.

Laboratory Technicians

As to the means for providing such laboratory service, I am convinced that, wherever possible, the non-medical technician should be employed. In view of the fact that in the larger centers it has been found advantageous to use non-medical workers, it seems to me even more imperative that this be done in the small hospitals. The objection that the expense of such a technician will be too great must be met. In the hospitals of fifty beds or more, such a technician can be provided who will also look after the case records and the x-ray department. For the smaller hospitals it will frequently be possible to train a ward nurse to perform these simple tests, while at the same time she might carry on some ward work. The non-medical full-time laboratory worker is, of course, the ideal towards which all hospitals should strive, as it is only when their laboratories are in such hands, directed, naturally, by the physician in charge, that they will achieve the best results.

The interpretation of the results of laboratory tests must rest with a graduate in medicine. The technician fit to carry on this sort of work should be trained in one of the large laboratory centers where it is possible to work under the supervision of the highly paid physicians who have specialized in laboratory technique. Technicians having had such training are competent to properly carry out this laboratory technique. Accuracy and speed can only be attained by long practice under proper supervision, and both accuracy and speed are essential in a laboratory technician. It is not to be expected that graduate physicians can be

employed for such work—the remuneration would be too low and the work too mechanical to justify them in such expenditure of time. Technicians for this work can only be properly trained in the larger hospital laboratories, and in this connection I may add that there has been inaugurated a technician's course at the Vancouver General Hospital that will fit a nurse to do the laboratory techniques as outlined, also the necessary x-ray work, as well as giving her a fundamental knowledge and experience in connection with medical records, particularly as to obtaining, classifying and filing same. A graduate nurse, after such a course, extending over ten months, during which time she spends two months on records, four months on laboratory work and four months on x-ray work, should be the ideal person to handle these three services which are so essential in all hospitals today.

The cost of a laboratory service as I have outlined will, of course, vary with the size of the hospital. The minimum initial cost should not be over $350.00, which I have itemized in the attached list. The cost of upkeep of the equipment and supplies would be between $50.00 and $60.00 per year. The salary of the technician would amount to $100.00 per month and keep (which would mean $135.00 per month). This would bring the total cost per month to about $140.00, which amount could be reduced in proportion to the time so spent, if the technician was working part time on records or other services.

The cost might be met in two ways: Firstly, by making a charge for each laboratory test; and secondly, by collecting a flat rate of so much from each patient per day. The latter of these is, I believe, preferable. The former tends to lay a heavy burden on the few that need a great deal of laboratory work, while the second plan divides the burden so that it is really not felt by anyone, yet it is no injustice because all patients will benefit by the laboratory service in the hospital. For example: In a hospital averaging fifty cases per day, there are fifteen hundred treatment days each month; a flat rate of 10c per day will yield $150.00 per month, or more than enough to provide such laboratory service. In those smaller hospitals not maintaining a full-time technician, the cost would be proportionally less.

This, therefore, sets forth, briefly, the fundamental and essential minimum laboratory service which should be found in every hospital desiring to do competent work and to take good care of their patients. From such a basis can be developed a much larger and more highly organized laboratory system as the institution grows in size, till finally, the various departments such as pathology, bacteriology, serology, clinical microscopy, blood chemistry, etc., are each organized, having a competent director and staff and giving an efficient maximum service to all hospitals.

List of Equipment for Laboratory for Hospitals of 100 Beds or Less

1 gross test tubes, 5 x ⅝, without lip.
1 gross test tubes, 8 x 1, for urines.
Tincture bottles, x x glass ware, ground glass, stoppered, 12—4-oz.
Tincture bottles, x x glass ware, ground glass, stoppered, 12—6-oz.
Flasks, Erlenmeyer, 4 100 c.c.
Flasks, Erlenmeyer, 4 250 c.c.
Flasks, Erlenmeyer, 4 500 c.c.
Flasks, Erlenmeyer, 2 1000 c.c.
3 Evaporating dishes, diameter 3 in.
2 lbs. assorted glass rods.
2 lbs. assorted glass tubing.
2 Burettes, Moher Shellbeck, capacity 50 c.c. Grad. 1/10 with pinchcock.
Pipettes, grad. 1/10 c.c. to tip—6 1 c.c.
Pipettes, grad. 1/10 c.c. to tip—4 5 c.c.
Pipettes, grad. 1/10 c.c. to tip—4 10 c.c.
Pipettes, volumetric—3 5 c.c.
Pipettes, volumetric—3 10 c.c.
Pipettes, volumetric—2 20 c.c.
Pipettes, volumetric—2 25 c.c.
Pipettes, volumetric—2 50 c.c.
Cylinders, measuring—2 10 c.c.
Cylinders, measuring—2 50 c.c.
Cylinders, measuring—2 100 c.c.
Cylinders, measuring—2 500 c.c.
6 T. K. Dropping bottles, capacity 60 c.c.
2 gross microscopic slides.
2 oz. coverslips, sq. 24 m.m.
2 Well slides.
2 Buntzen burners (or equivalent, depending on gas supply).
2 Iron tripods, 3 inches in diameter.
4 Pieces wire gauze with asbestos, 4 inches sq.
1 Centrifuge.
1 Hemacytometer.
1 Hemoglobinometer, Sahli.
1 Hemoglobinometer, Tallquist.
2 Esbach Albuminometers.
2 Urinometers with cylinders.
1 Microscope, B. & L., B.B.H., or equivalent.
2 Casseroles, capacity 150 c.c.
2 Forceps, dissecting, with fine points.
2 Forceps, dissecting, medium heavy, straight points, 115 m.m. long.
2 Forceps, coverslip.
4 Pencils for writing on glass (Blaisdell).
1 Colorimeter (Dunning).
1 Platinum loop.

NOTE:—This includes equipment only; supplies are not included.

ACADEMIC PROCESSION AT DEDICATION OF PEKING UNION MEDICAL COLLEGE

Many prominent physicians and surgeons were present in late September at the formal opening of the college which was erected and will be maintained by the Rockefeller Foundation. From left to right behind the marshal, who carries the baton, are: Dr. George de Schweinitz, professor of ophthalmology, University of Pennsylvania; Dr. Florence Sabin, professor of histology, Johns Hopkins University; Dr. S. S. Goldwater, director of Mt. Sinai Hospital, New York City; Mr. James L. Barton, secretary of the American Board of Foreign Missions; and Prof. T. Tuffier, surgeon at the Hospital de late Pitié, Paris.

THE HUMAN ELEMENT AS A FACTOR IN THE HOSPITAL LAUNDRY*

By WALTER TRIMBLE, Chicago, Ill.

The personal element in the hospital laundry is the most important element of all. Equip your department with the best and latest machinery but if you ignore its personnel you cannot hope for satisfactory results. In laundry workers you should first demand a reasonable amount of intelligence. Then you can start to build "morale," that greatest requisite to the production of satisfactory work. Discipline then follows morale, not morale discipline as is so often mistakenly believed. If you get harmony of relationships, gain the confidence of the employees, give them something to work and hope for, and place them in good working conditions you will have nothing to fear.

IN PREVIOUS articles much has been said about the machinery and the methods that are used in the hospital laundry, but there has not been much reference to the human element—the people who use the machinery and carry out the methods. The personnel of the working force should be given careful thought, however, for more depends on it than on anything else.

The manager of the laundry department is a part of its working force, although in a large institution he will not work with his hands. Without a suitable manager and suitable workers, the best equipped laundry plant that can be installed will not produce satisfactory results. I have read much about "machinery that seems to be able to think," but I never have seen any of it in a laundry or elsewhere. If there is any machinery in your laundry department "that seems to be able to think," it is the kind that walks around on two legs—and lots of these two-legged machines that I have seen working in laundries do not even "seem" to have reasoning faculties. Nevertheless, alleged managers employ such people, pay them as much as it would cost to get workers who can think, and expect such dullards to be able to operate complex machinery and carry out difficult methods.

The nearer a machine approaches to "thinking" ability, the more complex it necessarily becomes; therefore, the more brains it takes to operate it. In other words, labor-saving machinery saves labor, but it does not remove the necessity of the operatives' having brains; conversely, it increases the amount of intelligence that they must have. If any person tells you that a boy or girl can operate a complex machine, be sure to discount that statement, for behind the boy or girl, even if one can operate it, there must be an expert mechanic, whose duty it is to watch over machinery of this class. Whenever there is employed an operative without skill and intelligence there must also be a person employed to supply the missing attributes. It is an axiom that as the skill of the workers diminishes the expense of supervision increases.

Thus we see that one should have operatives who have at least a reasonable amount of intelligence. If one has this kind of a working force he will be able to get morale, the one great requisite to production of work which is both satisfactory in volume and quality. If one can maintain a good morale among the workers in his laundry department, his production problem should be a comparatively easy one, for in that event there is nothing to do but to follow standard practices.

Morale, according to Webster, means "condition, as affected by, or dependent upon, such mental factors as zeal, spirit, hope, confidence, etc.; a mental state." To secure morale one must, we see, have zealous and spirited human elements; then one must give them something to hope for, and must have their confidence. This, it is true, is a condition that is not easily brought about, but it is a state that is worth striving for.

Morale is often confused with discipline, which Webster defines as "training to act in accordance with established rules; accustoming to systematic and regular action; submissiveness to order and control; habit of obedience." Many men waste a great deal of time in trying to develop discipline first and morale afterward, which, as a little applied logic will show, is putting the cart before the horse.

Most of the workers in the laundry department are women, and as the keeping up of morale means the keeping of the women in a good mental state, the matter is one for mere men to ponder. The workers, we see, must be zealous, spirited, hopeful, and have confidence, if the collective morale of the operative force is to be high. How

*This is the thirteenth of a series of articles by Mr. Trimble on the hospital laundry appearing in THE MODERN HOSPITAL.

is one to be able to bring about this much-desired state of affairs?

Must Eliminate the Unfit

Going to the very root of things, one should begin with the employment of the operatives. If one has on his pay roll some unfit human elements, he must replace them. This may seem a cruel way to put it, but it is no more cruel than surgery, and really it is business surgery. The law of the survival of the fittest is cruel, but it is a law of nature, you must eliminate the unfit.

The first factor to be considered in the employment of a person to work in a hospital's laundry department is the physical fitness of the applicant, for no one can perform a task to which he or she is not physically adapted. Some tasks require a strong person and others do not. Do not try to fit square pegs in round holes and vice versa. The next consideration is the mentality of the applicant, or perhaps I should say the mental attitude. Select persons who have a cheerful disposition and who are willing to obey, rather than persons of strong mentality, for your rank and file. You want brains, of course, but you do not want people, especially women, who are too "strong-minded." The executives, of course, should be well-educated persons who are both cheerful and diplomatic.

Do You Pick Your Employees?

Your laundry department, if it is an average one, has a working force that is made up of a heterogeneous collection of men and women, most of whom were put to work merely because they happened along and applied for a position at a time when a worker was wanted, not because they were particularly fitted to their tasks. In other words, the workers picked you out to be their employer, instead of your picking them out to be your employees. If this is the case, you are facing a condition, and not a theory—and you want to bring the morale and discipline up to a reasonable standard.

Can this be done? It has been done, and this would indicate that it can be done again. Experience has shown that it costs but little to do it, and it brings a big return in the shape of lower cost of production and more satisfactory product. Perhaps you will not have to make any changes in the personnel of your working force, but it is probable that you will have to get rid of some unteachable persons and a disturbing element or two. First of all, get harmony. Then get the confidence of all and make all to feel that they will get a square deal.

The workers must have something to hope for, and here may be a stumbling block, for you may not have much to offer. But there is always something that the hospital management can offer to its laundry workers as a ray of hope, such as better pay for more and better work, with promotion for those who become fitted for advancement. Some workers never will deserve to advance, it is true, but the capable ones should always be able to hope for advancement.

Good Working Conditions Necessary

It should always be remembered that bad working conditions will make it almost impossible to build up a competent, loyal working force, for intelligent people seek employment where the environment is good. It should hardly be necessary to tell the manager of a hospital that his laundry department should be clean, well lighted, have plenty of ventilation, both forced and natural, and have suitable dressing rooms and toilet facilities, so I will not dwell on that subject. Welfare work, if done in the right manner and with the right spirit, is a great help, but if it is done wrong it is a great hindrance. This interesting and important subject will be left open for future discussion.

RED CROSS WORK IN NAVAL HOSPITALS

The work of the American Red Cross in keeping up the morale of the men in Navy hospitals has been summed up by Lieutenant Commander Joel T. Boone, of the Medical Corps of the Navy. He declares that home service as carried on by the Red Cross has been of incalculable value to the hospitals, and although it would be almost impossible to outline exactly the divisions of the work, yet it can be generally characterized under the following heads: Persuading men in the Navy to communicate with their families and the families to communicate with the men. Rendering assistance, upon request, in handling the business difficulties of the men or members of their families. Providing information regarding the Government's program for the welfare of the men, such as allotments, allowances, insurance, vocational training, etc., and assisting in handling difficulties in which the men are involved. Friendly visits to the men when sick or disabled, and keeping their families advised of their progress when advisable, and when approved by the commanding officer. Investigations of home conditions, at the request of naval officers, for confidential information needed in considering questions of medical care and treatment, as well as furlough or discharge. Locating families of men in the service or locating men for inquiring families. Arranging friendly visits to families on request of men in the service.

To carry on these activities, the Red Cross has representatives stationed at the larger hospitals, at some there is even quite a staff of workers. A great deal of what these splendid women are doing is as hard to define as morale itself.

The board of trustees of the Toledo Hospital, Toledo, Ohio, has sent Superintendent P. W. Behrens and Mrs. Behrens on a European tour. They will visit hospitals of note while abroad and observe methods of construction and administration.

THE STANDARDIZATION PROGRAM FROM A SUPERINTENDENT'S STANDPOINT*

By WAYNMAN CRANE LYON, Superintendent, Springfield Hospital, Springfield, Mass.

IN CONSIDERING the standardization program from the superintendent's standpoint, we will divide the minimum requirements into three general divisions: First, accurate and complete case records; second, adequate clinical laboratory facilities; third, organization of the physicians and surgeons who are privileged to treat patients in the hospital into a staff or group, including membership, rules and staff or group meetings. I believe that we are all familiar with the reasons why the standardization program was undertaken, and also the importance as well as the necessity of all hospitals meeting the minimum requirements. The next question is, "Has experience shown so far that the program has produced any beneficial results where it has been adopted?" From the superintendent's standpoint I would say unqualifiedly "Yes."

Benefits Patient for Whom Hospital Exists

In considering the practical working of any program in connection with hospitals, we must never lose sight of the fact that the hospital exists primarily for the care and treatment of the patient, and in judging results, we must ask the question, "Has this program benefited the patient either directly or indirectly?" The patient places absolute confidence in the hospital together with the physician or surgeon under whose care he is, and therefore believes, and has a right to believe, that everything which is humanly possible, will be done for him by the hospital through means of an efficient organization of trained workers and by the aid of all necessary facilities and equipment for the proper diagnosis and treatment of his case. Experience thus far has shown us that this is exactly what the minimum requirements of the standardization program, when carried out, guarantee to the individual patient.

In the first place, accurate and complete case records are absolutely essential and invaluable for two reasons: First, the necessity of having the information contained therein, available, and an accurate record kept of the patient's condition and treatment from day to day, while in the hospital, for use of the physician or surgeon in charge of the case, in order that the proper treatment may be given him; second, to have this accurate and complete record instantly available, at any future date, for the information and guidance of any physician treating this patient for some new condition or a recurrence of the old trouble.

Obligation to Patient Calls for Records

No one realizes better than the superintendent, the innumerable occasions when information of this kind is called for, frequently a number of years after the patient has left the hospital. It is unfair to the patient, as well as most embarrassing to the superintendent, if he is able to produce only the very meager and limited information that many hospital records of ten or even five years ago contained. However, the adoption of the standardization program has entirely eliminated this unjust and unfortunate condition, and now the superintendent of any hospital which has met the minimum requirements, can produce at any time, when called for, an accurate and comprehensive history of every patient who has been treated in the hospital.

As time goes on, requests from other hospitals as well as individual doctors for the records of patients, will become more numerous. The fact that all hospitals now meeting the minimum requirements have a more or less uniform set of records, which contain all of the essential information necessary, will be of inestimable value in the future. At the present time, the Springfield Hospital is successfully using trained historians for the securing of all histories in order to have the information contained in them as uniform and complete as possible. These historians, who are graduate nurses, in taking the patient's history, are guided by an outline of general questions to be asked, covering all the essential points. This outline, of course, is flexible, and after receiving answers to the first few leading questions, the historian is enabled to decide which one of the several groups of detailed questions is the proper one to follow, in order to secure the necessary and desired information from the patient. This detailed and uniform history in all similar cases, is particularly valuable to the staff or individual member, when studying a series of cases of the same disease.

Records Sometimes Needed in Court

Accurate and complete case records are of the utmost importance in many other ways, which can only be fully appreciated from the superin-

*Paper read at the hospital section of the American College of Surgeons meeting held at Springfield, Mass., May 13, 1921.

tendent's standpoint, one of which is the absolute necessity of having them available when called upon to produce such records for use in court. It is certainly a decided reflection not only upon the superintendent, but the hospital as well, if an accurate and complete record cannot be produced. In these cases the record is no longer considered as confidential, but it is read in the court room, and the public has an opportunity to judge for itself, whether or not the hospital is meeting its obligation to the patient in this particular. The opportunity for criticisms of this kind is entirely eliminated by the adoption of the standardization program. Any hospital which has met the minimum requirements will certainly have cause to feel proud of its records, when it is compelled to make such records public. They will reflect credit on the organization and develop favorable public opinion toward the hospital. No hospital can exist today without the good will and support of the public in the community in which it is situated.

Having spent effort, time, as well as money, in perfecting an accurate and complete record system, it is of the utmost importance that infinite care be taken of these records, and that they be permanently filed so as to be instantly available. Since these records may be at any time of the greatest value and service to a patient or his relatives, the hospital is certainly under the greatest obligation to take every precaution against any record being lost or destroyed.

In considering the question of adequate clinical laboratory facilities from the superintendent's standpoint, it is a fact that the public has the right to expect and demand that all necessary facilities, as well as equipment be provided by the hospital for the proper examination and treatment of patients. The public, during the past few years, has been educated to realize the value, as well as the necessity of adequate laboratory and x-ray facilities to assist in diagnosis. Any institution is assuming a grave responsibility when willing to continue admitting and treating patients, where these facilities are not available.

Organization of Physicians Most Important

By far the most important of the three above mentioned divisions of the minimum requirements, from the superintendent's point of view, is the organization of the physicians and surgeons who are privileged to treat patients in the hospital. This group organization and the adoption of definite rules governing it, together with the monthly group meetings, has done more than any other one thing in establishing a spirit of cooperation throughout the entire hospital organization. This is, of course, of the utmost importance and assistance to the superintendent. The adoption of rules governing the group organization has eliminated all incompetent physicians and surgeons, as well as those who are unworthy in character and in matters of professional ethics, and this has automatically solved many of the most perplexing and delicate problems of the superintendent. Should it become necessary to deny a doctor the privileges of the hospital for one of the above reasons, it can no longer be construed as a personal matter between such doctor and the superintendent, but it at once becomes an issue between the hospital as an organization, representing the rights of the patient, and the doctor.

By far the most valuable phase of the group organization, is the monthly group meeting. This is attended by all of the doctors who have treated patients in the hospital during the preceding month. In the case of the Springfield Hospital, the first thing taken up at these group meetings is the presentation of any interesting pathological material collected during the month, with such remarks as the pathologist deems helpful. Or it may be a ten or fifteen minute paper read by one of the doctors on some particular subject of interest to the entire group, this subject having been announced at the previous meeting in order that all may enter intelligently into the discussion.

Casualty Report Read and Discussed

Then comes the reading of the registrar's casualty report, and its discussion by physicians and surgeons responsible for the case or cases in question. The details, as shown by the case histories and testimony of those concerned, are carefully considered by the group, in order that it may determine as far as possible whether the fault lay with the doctor, the patient, the disease, the hospital organization or equipment. This casualty report, and by casualties we mean deaths, infections or complications, becomes a part of the hospital record, and includes the following information:

(a) Serial case number of patient.
(b) Name of physician or surgeon under whose service the casualty occurred.
(c) Percentage of casualties to the number of cases treated that month by physician or surgeon concerned.
(d) Nature of casualty, i.e., death, infection or complication, etc.
(e) Diagnosis, pre- and post-operative.
(f) Nature of operation, if any.

In other words, this report is an absolute record of the work done and accomplished by the hospital during the preceding month, and at the end of the year, a summary is made covering the work

of the preceding twelve months, and becomes part of the permanent hospital records. The results of the work done by the hospital, as shown in this report, should be the basis of deciding whether or not the hospital is justified in assuming the responsibility of treating patients and of looking to the public for support. By this method of group meetings, the superintendent knows at once if casualties are occurring which it is in any way possible to prevent, and furthermore, knows where the responsibility rests and how the trouble may be corrected.

Considering the standardization program in its entirety, one of the most important features, is the fact that the hospital, having met the minimum requirements, is in a position to go before the public when in need of funds, with the statement that it is on the approved list of hospitals, which have been investigated and classified under the standardization program of the American College of Surgeons, and is therefore worthy of the confidence and support of the community, inasmuch as it is meeting its obligations to its patients.

However, it is not sufficient for hospitals to only meet the minimum requirements in a literal sense, because compelled to, but they must enter into the spirit behind the program, if they would derive the full benefit from it.

Accurate and complete case records in themselves mean but little, if they are not conscientiously written and intelligently studied. Thousands of dollars may be spent in equipping clinical laboratories, but it is money thrown away if the facilities thus provided are not taken advantage of and intelligently used in treating cases. The staff may be organized, innumerable rules and regulations adopted, monthly, weekly or even daily meetings held, but they will be productive of no good results unless each individual member realizing his responsibility to his patients, lives up to the spirit of such rules and regulations, and conscientiously attends these meetings in a cooperative spirit.

Therefore, the adoption of the standardization program will produce beneficial results in direct ratio to the conscientious effort expended and the spirit of cooperation with which it is entered into, by the entire hospital organization.

LAURA FRANKLIN FREE HOSPITAL TO BE PART OF FIFTH AVENUE INSTITUTION

The Laura Franklin Free Hospital for Children on East 111th Street, New York City, will become a part of the new Fifth Avenue Hospital on January 1. It will be concentrated on one floor and in its new quarters will be able to take care of twice as many babies as before and in a way not possible in the old quarters. Instead of the little back yard for a playground the children will have three special playrooms, one indoors fitted up with all kinds of toys and games, one outdoors, and a third a loggia playroom where the children will have the benefit of sun, light and air all the year round.

The Laura Franklin Hospital was founded in 1885 by Mr. and Mrs. Franklin Delano in memory of their niece, Laura Franklin Delano, and it has been entirely supported by this family ever since.

CELEBRATE 100 YEARS OF SERVICE

In celebration of a full century's service in the hospital field, the Massachusetts General Hospital in Boston on October 18 held formal exercises. The observance was a dual celebration of the admission of the first patient to the hospital in the autumn of 1821, and of the seventy-fifth anniversary of the discovery of the surgical use of ether, credited to that institution.

The Massachusetts General Hospital has had a remarkable history and lays claim to the following advances in medical science:

The demonstration of surgical anesthesia on October 16, 1846, by Dr. William T. G. Morton. The patient was Gilbert Allen and the surgeon Dr. John C. Warren. Dr. Morton was last year admitted to the Hall of Fame for this discovery, the only physician ever so honored. From his demonstration the knowledge of surgical anesthesia spread throughout the world.

The demonstration of appendicitis by Dr. Reginald H. Fitz.

The work on puerperal fever by Dr. Oliver Wendell Holmes.

Dr. Richard C. Cabot's demonstration of the value of social service in hospitals.

The demonstration by Dr. E. A. Codman of the value of surgical audit and the follow-up of patients.

On September 1, 1821, was admitted the first patient to the general hospital, it being chartered in 1811 but delayed in opening by the War of 1812 and the subsequent financial depression. McLean Hospital, a branch of the Massachusetts General, admitted its first patient in 1818 as the trustees were able to start the branch for the insane earlier because the buildings and estate of a Somerville citizen could be used.

The anniversary celebration took the form of demonstrations and clinics for the hospital alumni and visiting physicians in the morning and formal exercises in the afternoon.

Presentation to the hospital of a tablet honoring alumni of the hospital who lost their lives in the World War was made in Treadwell library at impressive exercises during the day. The presentation address was made by Dr. Samuel J. Mixter, president of the alumni association. George Wigglesworth, chairman of the hospital board of trustees, accepted the tablet in behalf of the hospital.

Following a luncheon for alumni, formal exercises of the day were held before a large audience in the assembly hall of the Moseley Memorial Building. Dr. Henry P. Walcott presided and addresses were made by Dr. Frederick C. Shattuck for medicine, Dr. Harvey Cushing for surgery, Dr. C. Macfie Campbell for psychiatry, and Maj. Gen. Merritte W. Ireland for the modern development of a civil hospital as an asset to the country in time of war.

In the evening the House Pupils' Alumni Association dined at the Harvard club where speakers were: Maj. Gen. Ireland, surgeon general of the army, and Bishop William Lawrence of the Episcopal Diocese of Massachusetts. Dr. Mixter presided; 100 alumni were present.

The MODERN HOSPITAL

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THE DISTRIBUTION OF HOSPITAL FACILITIES FOR WAR VETERANS

ON SEPTEMBER 21 Senator Stanley of Kentucky introduced senate bill No. 2458, providing for a $5,000,000 hospital for veterans suffering from nervous or mental diseases. The bill contains a provision which suggests that the proposed hospital be located in the District of Columbia. This site, however, is not mandatory. Immediately after the bill was introduced, an agitation was started to have the hospital, if the bill passed, located in the District of Columbia, and the director of the Veterans' Bureau issued a public statement in which he favored the location of the hospital in the city of Washington or near the national capital.

THE MODERN HOSPITAL and others who are familiar with the country's need of hospitals for mental and nervous cases among ex-service men, are convinced that it would be a serious mistake to build a 1,000 bed hospital for these patients at this point. Washington already has 1,050 beds for neuro-psychiatric patients, at the Walter Reed and St. Elizabeth Hospitals, a number more than enough to meet the needs of the ex-service men in a wide area, as well as the special needs of such a city as Washington, to which patients from the army, the navy and the civilian federal service are constantly being referred for accommodations. Moreover, at Perryville and Philadelphia, both within 150 miles of Washington, there are located two of the six neuro-psychiatric hospitals of the United States Public Health Service. They draw from a still wider area.

If the proposed hospital is located at Washington the principle which actuated the White committee in distributing hospitals of not more than 500 beds about the country so as to give a fairly convenient service to the larger population groups in proportion to the known incidence and the expected incidence of neuro-psychiatric diseases among the veterans, will go by the board. Is it the part of wisdom thus to ignore not only the fundamental advantages and medical benefits which will accrue to patients by being located near their families, but also the reasonable and natural human wishes of the families and friends of the patients that they be treated in nearby hospitals?

What of the need of the far west, the northwest and the south? Shall the patients of these regions be transported at great expense to Washington, and thus be separated as far as possible from their friends? Indeed, the complete lack of adequate facilities anywhere on the west coast made it necessary on August 26 of last year to transfer a violently insane discharged soldier from Letterman General Hospital, located at San Francisco, to St. Elizabeth Hospital at Washington, D. C.

Many of the patients who are beneficiaries of the Veterans' Bureau are suffering from temporary, curable forms of neuro-psychiatric diseases, and hospitals should be located near the bulk of the men in order to tempt them to undergo early

The very great victory on behalf of disarmament and peace achieved by the nations of the world should be an inspiration to the members of the American Hospital Association, giving us courage to meet our common problems, stimulating our endeavor to elevate the standard of care for the sick and injured, remembering at this season, and throughout the year, that he serves God best, who serves his fellowmen.

Ginzel Hurd

President, American Hospital Association.

care and treatment. Experience has shown that beneficiaries are unwilling to go to distant institutions, where friendly supervision and contact are impossible.

The location of the proposed hospital at Washington will only increase the disproportion between the facilities which have been provided in the East and those which are so badly needed in the South, the Southwest and the North. So serious a mistake should not be countenanced.

EMPLOYING A SPECIALIST FOR HOSPITAL FINANCIAL CAMPAIGNS

NOT infrequently hospitals in need of capital for the construction of new buildings and, less often, for maintenance, turn to financial compaign specialists to assist them in raising funds. This is especially true in communities which have not as yet banded their private civic and philanthropic agencies into a financial federation, or whose activities are too few to make such a federation practicable.

It is not our purpose at this time to discuss the merits or demerits of the campaign method of raising money, but various inquiries from our readers prompt us to comment briefly on the question of employing campaign specialists. Where local leadership for financial campaign work has not been available, honorable, competent campaign specialists have assisted various hospitals in organizing campaigns of this character, and have often done so in a way that has won many friends for the institution. But the campaign method is not without its dangerous elements. The personality and capability of the campaign director may not bear investigation; his methods may not stand critical analysis; the purpose for which the money is to be raised may not be justified; or the campaign itself may not be acceptable to recognized leaders of the community. These dangerous elements may be guarded against if hospital authorities will take certain precautions.

No campaign should be entered upon until a competent, disinterested person or organization has first determined by a local survey of the community's needs that the proposed hospital or addition to a hospital is necessary. Moreover, the facts which establish the claim should be submitted to the public for review. This will serve to assure the public of the soundness of the investment it is asked to make.

The campaign director should not be employed on the strength of hearsay evidence or of any printed matter he may issue as to his capabilities. A thorough critical investigation should be made, both of the man and of his methods.

It is indeed most appropriate to send a message of good will, encouragement and gratitude to the hospitals at this blessed season of Christmas, as the hospitals are the direct fruit of the teachings of Him who came to bring spiritual health to all and who taught the true value of corporal works of mercy.

Americans should be most grateful for the skill of the surgeons and physicians, for the tirelessness and tenderness of the nurses, and for the countless sacrifices of the general staff in our many homes of mercy, called hospitals. Let us hope that during the coming year the good work will be increased not only in the large centers of population but also in the rural districts, where additional facilities are greatly needed.

May Christ, the Great Healer, bless all engaged in hospital work and may His mercy, tenderness and sympathy be a constant example to those who have been called to assist suffering humanity.

P T Maldon

Bishop of Rockford,
Chairman, Department of Social Action, National Catholic Welfare Council.

The hospital's campaign committee and not the campaign specialist should hold itself responsible for the campaign, the persons conducting it, and any official statements or promises made during it.

The campaign committee should guarantee all the expenses of the campaign, and pay its director a salary. Commissions should be frowned upon. The desire to increase their income may tempt campaign specialists to secure contributions by measures that react most unfavorably upon the hospital and its place and influence in the community. Employing a director on a commission basis, moreover, gives unwilling contributors an opportunity to assert that if they contribute to the hospital during the campaign a portion of their gift will go into the pockets of the campaign specialist. Rather than have this happen they will refrain from giving altogether.

A finance committee should keep an accurate record in detail of the monies pledged, and the funds received during the campaign. For obvious reasons this should not be the responsibility of

the campaign director. At the end of the campaign the records should be audited by a certified public accountant, and the reports submitted either to the contributors or to the public at large.

It is believed that if hospitals will consider these suggestions in organizing and conducting their financial campaigns, they will have fewer failures and win many steadfast friends.

GRAVEYARDS AS MORALE BUILDERS

PLEASANT and stimulating surroundings, all will concede, are an important factor in helping the sick to get well. This unquestionable boon will be provided for the ex-soldiers in many of our government hospitals if the fourth recommendation contained in the report of the special senate committee, which has been investigating complaints of the inadequacy of soldiers' relief, is acted upon.

This recommendation provides that in all government hospitals where there is ground not in actual use for other purposes a sufficient cemetery be established for the burial of deceased, disabled veterans of the war.

Of the morale-building, health-giving quality of graveyards planted next to hospitals there can be no question. A daily view of seriate tombstones glittering in the mid-day sun or standing in ghostly array under a moonlit sky cannot but act as a tonic upon painwracked bodies and jaded nerves. Indeed this applies with special force to our ex-soldiers, all of whom are supposed to have made death their pal in the grim conflicts of war. As the convalescent boys take their daily outdoor constitutional, what more inspiring diversion than to walk among the graves of their departed dead and meditate upon the inspiring legends on the tombstones! Could any other daily regimen be more conducive to their rapid recovery? Take as an example the Edward Hines, Jr. Hospital, with its 320 acres of ground. Fully 300 acres of this generous expanse might, with excellent psychic effect upon the ex-soldier patients, be dotted with the graves of their comrades in arms. Surely the $250,000 which Congress has made available for beautifying the grounds of this institution could not be used to better advantage than to landscape it for a cemetery. For economy's sake at least, let our government hospital grounds serve the double purpose of housing the sick and furnishing a resting place for the dead.

In all seriousness, would not committees of the House and Senate display commendable wisdom if in the future they were to avail themselves of the technical knowledge and advice which is always at their command in the offices of the surgeons general of the Army, the Navy and the Public Health Service when dealing with institutional medical problems of this character?

PUBLIC HOSPITAL SYSTEM OF NEW YORK UP FOR STUDY

THE organization and administration of the public hospital system of New York City has long been regarded as unsatisfactory. Of the seventeen hospitals conducted by this city, seven are administered by the department of public welfare, five by Bellevue and Allied Hospitals and five by the department of health. These three departments act for the most part independently. The result is a pronounced overlapping of functions with resulting inefficiency and waste. Tuberculosis, for example, is treated to some extent in Bellevue and Allied Hospitals, to a considerable degree in the hospitals of the department of public welfare, and finally in the hospitals of the department of health, nearly one-half of whose total number of days of treatment is supplied for the care and treatment of tuberculous patients. Four of the five hospitals in the Bellevue and Allied Hospitals group and six of the seven hospitals conducted by the department of public welfare are doing general hospital work in a way that duplicates effort.

To meet the ever-changing and increasing needs of a rapidly growing city, whose population shifts so constantly, new, and the occasional relocation of old, hospitals and dispensaries, are constantly demanded of the city, particularly in locations where private initiative is not apt to supply the need. Under the present unsatisfactory situation, however, no one department is charged with the responsibility of studying the hospital situation as a whole, in order to determine what additional and altered facilities should be provided by the city and to supervise the non-municipal hospitals in regard to such aspects of their development, location and work as may concern the city.

Various changes that have been proposed officially and unofficially since the consolidation of the Greater City, are symptomatic of the long-standing dissatisfaction with the situation. Space will not permit us to review these proposals. All point to a consolidation of the service in the interest of economy and efficiency. Up to the present, however, none of these plans have been acted upon mainly because they require radical amendment of the city charter. But a change for the better seems imminent. The Meyer committee, a joint legislative committee appointed by the state legislature of 1921 to investigate the government of the city of New York, has been looking into the question of the most desirable organization

and administration of New York City's public hospital system. It is presumed that the findings and recommendations of this committee will be turned over to the charter revision commission which was appointed by the governor of the state under authority of the state legislature, and which will probably report its recommendations to the legislative session of 1922.

The Meyer committee invited a number of individuals and agencies familiar with the hospital situation in New York to offer criticisms and suggestions, among them the New York State Board of Charities. In reply to the committee's request this board has recommended the establishment of a department of hospitals and dispensaries. The duties of the proposed new department would be to administer all of the public hospitals and dispensaries of the city of New York, now existing or to be created; to assume the duties devolving upon New York's Board of Ambulance Service; to make provision for the care of the sick poor in their homes; and finally to supervise the non-municipal hospitals, with reference to such aspects of their location, work and development as may concern the city government. This department would be administered by a single commissioner, whose qualifications should be so stated in the city charter as to insure the appointment of a person who possessed the educational attainments, technical knowledge and administrative ability which would enable him to carry on the work of the department successfully.

Some such consolidation and control as is here suggested is, it would seem, highly desirable, and should receive the hearty support of all who wish to see the public hospital system of New York City well organized.

MISS GOODRICH GIVEN DEGREE

IN NURSING circles the name of Annie W. Goodrich is one to conjure with, because she is one of the best loved leaders in the nursing profession. It is probable that Mount Holyoke College has little conception of how it has endeared itself to nurses by conferring on Miss Goodrich the honorary degree of Doctor of Science.

The celebration of Founders' Day on October 8 was made the occasion for this ceremony, and although the newspaper accounts referred to Miss Goodrich's conception and development of the Army School of Nursing as her outstanding achievement, her peace-time conquests of difficult problems in connection with the progress of nursing education are quite as fruitful a contribution to human betterment as the Army School of Nursing, brilliant and dramatic as that was.

Through the columns of The Modern Hospital, I send my Christmas greetings to medical officers in charge, officers, employees and patients of United States Marine and Public Health Service Hospitals; also, to the personnel and patients of all other hospitals to which The Modern Hospital carries its valuable information and cheerfulness from month to month.

My earnest wish is that you may be immersed in the current of Christmas joy; that all despondency will be displaced by hope; and that a Merry Christmas will be followed by a bright and happy New Year.

Surgeon General, U. S. Public Health Service.

Miss Goodrich is to be congratulated on this well-earned distinction, but even more is the nursing profession to be congratulated that she is one of them. They may with good reason be proud to have the name of such a worthy representative of the highest ideals of nursing service added to the growing list of notable women who have been singled out for such honor.

Miss Julia C. Stimson, who followed Miss Goodrich as head of the Army School, received a similar degree at the same time.

"THE SAME OLD STORY"

In speaking of hospital publicity, Ralph Welles Keeler, director of publicity of the Methodist Episcopal hospitals and homes said:

"That which is daily routine to us is often of interest to those who have never heard of it, if presented to them in an attractive way. There is a bit of philosophy for us right here in the advertisement of Associated Engravers, Incorporated, in the Advertising Club of New York City. Under the title 'The Same Old Story,' the following is printed:

" 'The leader of the orchestra doesn't like even the best show after the first twenty nights. He hates the comedian and the same old jokes.

" 'But the box office receipts pile up. The theater is crowded. The people laugh at the same old stories (or what the orchestra thinks are the same old stories.)

" 'So, when we are apt to grow tired of talking about real engraving service, about making the best of engravings we can and of our ideas of friendship in business—we remember that in this instance we have the viewpoint of the orchestra leader—and we keep on telling the same old story.' "

HOW SOME NEW YORK AND CHICAGO HOSPITALS SPENT CHRISTMAS, 1920

CUSTOM in all the large Chicago and New York hospitals decrees that Christmas every year shall be the brightest, happiest, and best of all the days of the year, but hospital officials are unanimous in saying that the Christmas of 1919 excelled all others in the spontaneous giving of money, time, and labor by hospital boards, nurses, physicians, and friends of the hospitals and in the joy experienced by both the children and the adult patients, and, incidentally, the donors.

NEW YORK CITY HOSPITAL

When you are two thousand miles away from home at Christmas, for the first time in twenty-five years, and in a city hospital at that, you wonder if you will miss the cheerful "Christmas gift" greetings and the spirit of good-will and happiness which pervades the holidays at home. However, in the New York City Hospital, there was no cause to worry, for an unusual spirit of peace on earth, good-will toward man, seemed to be thrown over all the inmates of this big institution — patients, employees, doctors, and nurses. For a little while the patients forgot their pains and aches and again enjoyed a real Christmas dinner and the coming of Santa Claus with his bag of gifts; the nurses moved with winged feet and forgot how long the day could be; the doctors hid their pill-bags and stethoscopes and helped with the decoration and entertainment.

Every hospital ward has its own glittering Christmas tree, which friends and generous-spirited strangers have decked with gifts.

A few days before Christmas one of the largest wards was temporarily emptied, a stage erected, and a huge Christmas tree installed, with colored lights and all the "fixings." The walking patients and those who could possibly leave their beds for a few hours assembled there for an afternoon's fun. Through the kindness of friends and officials of the hospital, some of the best vaudeville entertainers in the city came over to aid in the merry making. They were all there—the magician, the black-faced comedians, and the musicians. Santa Claus arrived on the scene, to the great delight of the children. Then that favorite of young and old, Charlie Chaplin, appeared on the screen in "Shoulder Arms." The musicians afterward went around to the wards and played for the patients who could not go to the party. Ice cream for all did its share to complete the afternoon's enjoyment.

Do you believe in Christmas fairies? There is one that visits this hospital every year and gladdens hundreds by her coming. Long before the Great Day arrives she flutters around each hospital ward and finds out what each one desires most of all. Last year the presents arrived on Christmas eve and were delivered with the aid of the hospital officials and the social workers. The fairy gave of the best of her stores, and tried to get each patient his or her heart's desire. One little crippled lad wanted a wheel chair and on Christmas eve Santa Claus rolled in one of the best to be had. A patient in a neurological ward wanted a stuffed duck of the eating variety, and was the envy of his fellow patients when one arrived good enough for a king to eat. The little new mother at Maternity was very pleased when her wished-for gift came—two pairs of white kid gloves. Many of the presents were very useful and added much to the comfort of the patients—warm bath-robes, shoes, coats, hot-water bags, and other things. Nor were the children forgotten; there were dolls for the girls and squeaky, noisy things for the boys, with queer objects that run on wheels, and bags of nuts, candy, and oranges for all.

The nurses, with many willing hands to assist, made their wards festive for the holidays. Bells, holly wreaths, festoons, and tiny Christmas trees made the wards quite cheerful. A huge bowl of fruit and nuts was ornamental for a while, and then was passed around to the patients. All were given new clothes, being allowed to choose their own favorite color—blue, pink, or brown. At dinner time a large table was set in in each ward, gaily decorated with red crepe paper, and the bowl of fruit for a centerpiece. A real Christmas dinner was served, with turkey and dressing and cranberry sauce, and all the other good things. Early in the afternoon the visitors began to arrive to gladden the hearts of their friends and relatives with more gifts and cheerful greetings. The "Jesus women," as the patients call the missionaries, came with kindly words and baskets of fruit and flowers for those who had no friends. Everything combined to produce the real spirit of Christmas.

COOK COUNTY HOSPITAL

The same spirit of generous giving which made Christmas, 1920, a gala occasion in other hospitals was evident at Cook County Hospital. For the 1,300 wards of the county, the holiday season began on December 19, that being the last day of school. This was celebrated with a program of recitations and songs, and the little performers did their stunts in the most approved fashion, regardless of bandaged arms, legs and heads.

But even before that eventful day the gifts from the hundreds of prodigal Santas began to arrive. Never before in the history of the institution had there been so much received for distribution, and the wards kept in reserve enough to keep up with the wreckage for months to come. The plan was for social service department workers to get a list from each supervisor of the number in her section needing certain articles, and then so far as possible to fill those orders. None of the small patients cared to leave the hospital at this interesting period, even though they had sufficiently recovered to be removed. They begged to be permitted to stay and, after the festivities were over, made a solemn vow to be on hand again the next year, even if they had to get run over by a motorcycle to accomplish the feat.

And small wonder! For there were Christmas trees everywhere—upstairs, downstairs, in the corridors. There were even three out of doors on the south side between the wings—it would be easier to tell where there were none—so that the great, grim building assumed a very creditable imitation of fairyland.

Decorations were practically all made by patients, and the county furnished trees and holly wreaths. There was strong competition among the various supervisors, each making a strenuous effort to have her ward appear the most attractive. Ward 41, one of the children's wards, was, as usual, attractive. There was a little manger in one end with the Christ child and the Wise Men, and an angel or two. The children adored it.

Ward 31, which is children's surgical, had the best time. No one was very sick and their Christmas started on the afternoon before around the lovely Christmas tree in the play room, the gift of the Englewood Woman's Club. When they went to bed they refused to go to sleep until the night nurses hung their stockings, and when the nurses, singing carols, as is their yearly custom, came around about five o'clock in the morning, up they started again. They tried out everything in their possession that would make a noise, until they had to be subdued for the good of the rest of the house.

As for music, those who were privileged to listen to elaborate programs rendered by artists in the churches and elsewhere were no more favored than were the patients at the county hospital. On Christmas Eve the sweet-voiced surpliced choir of the New First Church came over and sang from floor to floor. The Third Presbyterian church choir was at the other end of the building, singing its beautiful carols. The story of the Christ Child was told in song, on the violin, piano and 'cello.

Then on Christmas day, there was the wonderful turkey dinner, with mashed potatoes and one other vegetable, gravy, celery, bread, butter, coffee, pie, fruit and nuts, served at noon to everybody who was able to eat. The tables had flowers or small Christmas trees for decorations, and the bed patients' trays had napkins with Christmas colors instead of the ordinary white.

In the afternoon Mr. Zimmer had arranged for an entertainment in Ward 20, which was fitted up with a stage. Everyone in the house who could get there came to the show. Entertainers from almost every theater in the city came and did stunts for the entertainment. Mr. Zimmer sent his piano from ward to ward so that each bed-ridden patient could have some share in the Christmas happiness.

Members of Bishop Kettler Council, Knights of Columbus, sent their glee club and a chorus of fifty voices to sing in every ward. Services were held in the beautifully decorated chapel on Christmas morning for all Catholics, and at midnight on Christmas Eve for the Episcopalians.

Dear old Santa Claus never passes up Wesley Memorial Hospital. He comes early and remains to the limit.

Christmas, New Year's Day, Thanksgiving, Hallowe'en, Fourth of July, and Memorial Day are always special occasions at Wesley. The little ones may be deprived of home and mother, but they do not lose the cheer and glad times provided by the considerate trained nurse in charge. Beautiful stories are told, recitations are given, and appropriate songs rendered. A group of nurses, especially appointed, sing Christmas carols. Of course, the climax is reached when Santa Claus appears. He is always accompanied, when visiting Wesley, by Mrs. Santa Claus. For the Christmas celebration a large ward is cleared and the room tastefully decorated with the idea of eliminating the atmosphere of the sick room as much as possible. A tall and shapely tree is provided with the usual decorations. Chairs are placed in the space about the tree, and room is provided for wheel chairs. Convalescing patients greatly enjoy the occasion and never fail to be present. The superintendent of nurses and her staff plan weeks ahead for the gay festivities of Christmas.

During Christmas week Wesley provides a Christmas tree and a party for the nurses in training, where they may for the time being forget the exacting requirements of their service to the suffering ones and join in the happy festivities of Mr. and Mrs. Santa Claus. The dispensary of the Northwestern University medical school, which is situated just next door, is also honored by an official visit from Santa Claus. He is accompanied by a group of nurses, who distribute candies and presents. The welcome on the part of the children is most hearty and is usually expressed by loud cheers, blowing of horns, and cries of "Santa! Oh Santa! Please shake hands with me."

HOSPITAL BETTERMENT IN CALIFORNIA

The League for the Conservation of Public Health in California has planned a Hospital Betterment Movement, or a "service" program for hospitals. It is, according to the *California State Journal of Medicine*, designed to bring the hospitals to the highest point of efficiency as an effective part of the program of better medicine and better health. The effort has little to do with so-called "standardization"; in fact the officers of the League believe that hospitals cannot, nor is it desirable to have them, become standardized any more than it is desirable to standardize the practice of medicine.

The good hospital must be a part of the application of the principles of science and art and economics as they enter into the practice of medicine to the prevention and cure of disease. As "personality" forms an important part of the qualification of the physician so must it of the successful hospital. This personality must be expressed in the giving of efficient, careful and sympathetic service to the sick. To make hospitals alike would be, in the opinion of the officers, to lead them toward mediocrity.

USING THE FINGERS TO CURE THE LUNGS

By H. A. PATTISON, M.D., Supervisor of Medical Service, National Tuberculosis Association, New York, N. Y.

IT HAS often been said that successful treatment of tuberculosis depends to a very large extent upon the fullest cooperation of the patient. Unless the person afflicted with the disease will follow the course of living laid down for him by his physician, his chances for recovery are much reduced, but observation in thousands of cases has shown that for the best results the patient must not merely do what he is told to do, but must do it cheerfully and willingly. How to keep the patient's mind occupied with something besides thoughts of his own condition has always been a problem which now seems to have been met in many cases by occupational therapy.

Reduced to its simplest terms, "occupational therapy" means the occupying of the hands and mind of the convalescent patient with light work which will assist in effecting a cure. Occupational therapy was used with success long before the World War broke out, but during the war period great numbers of service men sent to hospitals either because of wounds or disease naturally became subjects for this form of treatment. In the case of these men, stricken in the prime of life, occupational therapy served as a necessary means of bridging the period between their convalescence and their entrance into vocational schools which would fit them for useful positions in civil life.

Occupational therapy, speaking in a broad sense, is divided into three parts, as there are practically three parts in its remedial application. These are diversional therapy, occupational or handicraft therapy and pre-vocational therapy.

Diversional therapy comprises simple amusements which the patient can enjoy while still in bed. Games and puzzles which require skill in the use of the fingers and which divert the mind are all approved and have been used with success.

The next step is occupational or handicraft therapy. This involves the performance of definite tasks by the patient, such as the doing of useful things with woods, beads, textiles, clay and metals. In doing these things, the patient not only occupies his mind but is assisted in restoring lost and weakened function.

Industrial Recreation

Pre-vocational training is in reality the last step in occupation as a form of treatment, for this training means that the patient is employed in doing things which lead up to definite education for some industry, trade or profession.

All of these forms of occupational therapy have been called industrial recreation. This includes such forms of occupation as may be followed in some cases while the patient is still in bed. Basket-weaving, modeling, drafting, light carpentry, jewelry-making and photography are among the varieties of industrial recreation which naturally interest patients according to their tastes, and also have value as preparatory training for real work. Vocational training, as the name implies, means instruction in specialized forms of work under conditions approaching those existing in commercial institutions, and this training naturally does not come until the patient is really graduated from the ranks of the convalescent to the army of the well and strong. In fact, however, authorities do not include vocational education as a part of occupational therapy, although one naturally is a continuation of the other.

Since the purpose of occupational therapy is to interest the patient to such an extent in what he is doing that he will not brood over his own condition, the welcome given by patients to light tasks is evidence of the way in which this treatment fulfills its mission. To take only one example, the tuberculous soldiers in the army sanatorium at Oteen, N. C., are reported to be continually demanding higher standards of work. Dr. Herbert Hall, an authority on this subject, has said: "Short of actual drudgery, the more useful the work, the better its therapeutic results, and conversely, the more trivial and valueless the nature of the work, the less effective will it be in the therapeutic sense."

Variety of Appeals

Everywhere the effort is being made to offer to patients forms of occupation which will appeal to them. Of course, there are limitations to the variety of tasks in the earlier stages of occupational therapy, but in the pre-vocational period many odd forms of light work have been introduced. The care of flowers and bee-keeping are among those which have appealed to certain patients.

The extent to which occupational therapy has been applied is shown by a summary published in June of this year by the federal board for vocational education. According to this, in 44 hospitals, public and private, exclusively for tuberculosis patients who were ex-service men, 3,281 patients were enrolled for some form of occupational therapy or vocational training. This was out of a total of 3,929 patients who were well enough for such treatment. To be sure, these government figures do not distinguish between what may be technically called vocational therapy and vocational training, but they show the recorded fact that more than 84 per cent of the men in a condition to do so have enrolled for some form of training which will keep their minds busy with things other than their condition.

Occupational therapy has been provided for patients in all the state institutions in Wisconsin. The tuberculosis associations in New Jersey, California, Minnesota, New York and other states have organizers regularly employed to introduce this form of treatment into all county tuberculosis sanatoria in those states. The use of occupational therapy by former service men placed by the federal board in private hospitals has led in many cases to the application of this treatment to other patients there. In other words, it may be said that this manner of using the fingers to cure the lungs is coming more and more into favor.

Information regarding the progress of occupational therapy is constantly being gathered and disseminated by the National Tuberculosis Association and its 1,200 state and local organizations. This is only one of the many ways in which these organizations combat the disease which killed 132,000 Americans last year. Funds to carry on this work are derived from the sale of Tuberculosis Christmas Seals and the fourteenth annual Christmas seal sale will take place in December of this year. The response of the public in purchasing these seals will determine the extent to which anti-tuberculosis work can be carried forward in 1922.

NURSING EDUCATION*

By MARTIN H. FISCHER, M.D., Professor of Physiology, College of Medicine, University of Cincinnati, Cincinnati, Ohio

ARE we going to extremes in the matter of educating our nurses? Are we going to cast aside our three-year nursing course and adopt the new proposal, the quick and easy twelve-week course? That's the problem we have before us tonight.

Do not think that the problem concerns only doctors and hospitals. It is your problem. Some of us get through life without finding it necessary to call upon a lawyer or a minister, but every one of us sooner or later touches the doctor and the nurse. And what kind of individual are you going to permit to play with your entire capital? Should you lose your money, you can make more; but if you are robbed of your well being, your very existence is bankrupt.

The whole question is not new and, I may as well add for myself, the answer is not, either. I agree with the words of William H. Welch uttered some years ago:

"There has been at times criticism on the part even of leaders of the medical profession as to the position which the nurse desired to attain. There was a catch word at one time—one may possibly hear it today—that nurses were being over-educated. That it is possible for a nurse to know too much, to be too highly qualified on the practical, scientific and intellectual side of her profession is absurd."

The immediate cry has two sources. It is said that we have not enough nurses and that their expense places them beyond the reach of our great middle class.

The trained nurse is the exponent of a profession. The girl that touches our sick-bed today represents in training the collective and critical opinion of a half century in education. Do you honestly believe that an adequate substitute can be found for her by calling a downstairs maid, faithful for twelve weeks on the job, a nurse? The profession of the trained nurse is just like the profession of medicine. During the war there was a cry for more doctors and quickly; and the proposal was made that we cut down premedical requirements, shorten the medical curriculum and omit the compulsory internships. And yet at the same moment medical officers were telling us that the men we were sending them with all these extras attached knew not enough about fundamentals of medicine and surgery. Is the solution of any problem calling for competence ever solved by calling upon the less competent?

Nurses Becoming More Plentiful

Scarcity of nurses is not an acute disease but a chronic one. There never have been enough of the competent and the well-trained, and just now we are but emerging from a war in which the energies of any number of capable women have been diverted to factories and administrative offices. Along with the war came a pestilence. No wonder that with inadequate numbers of recruits and quadrupled needs for service, we found ourselves short. But these difficulties are passing. The hospitals this year have a full quota of pupil nurses.

The other cry is that our trained nurses are too expensive. Let us look at this, for a moment. Are we really desirous of having skilled workers labor for less than a living wage? How are we going to keep the physically, intellectually and socially fit entering the profession of nursing if the future does not promise them even a decent livelihood? The trained nurse gets less than the school teacher and the school teacher gets less than the half-skilled worker. If we are going to set standards which will appeal only to the maid of all work we will get that kind of service and nothing better. The question has been up in medicine. It has been argued that we ought to turn out poor doctors from our medical schools for poor districts and for the country. Now it is intended that we shall furnish these poor people poor nurses. And yet the poor laugh and cry and suffer remarkably like ourselves. The only difference is that they are far more stoical. Need I comment on such injustice?

Untrained Nurse Not Cheap

Is the untrained nurse, who is to come to us cheap, really cheap? Even this "natural" "God-given" nurse with all the shortcomings of her training cannot live below a minimum wage. And when opportunity offers, her moral standards are hardly such as will keep her from taking advantage of a critical situation. During the influenza epidemic when the trained nurse was receiving her twenty-five or thirty dollars a week, the untrained did not hesitate to take forty, fifty, and seventy dollars a week. Let us have no illusions about the matter. There may be plenty of women willing to enter twelve-week courses, but as soon thereafter as possible they will pass themselves off as skilled and trained nurses and demand their wages. To call a woman a nurse is not to make her such.

Professional nursing is not peculiar to the United States, but I do believe we do it a little better than other nations. There is a reason for this. We have been a little richer but also we have been a bit more democratic and politically a bit more eager for the universal square deal. If medicine had anything to give, we felt that its blessings ought to go equally to rich and poor. We have made nursing a sister profession to medicine.

Danger in Brief Training Period

Consider for a moment what you expect of a nurse. We have gone a long way since the times when a good neighbor woman, kindly in spirit but badly educated, "set up" with an individual—and watched him die. If you know how through the application of the teachings of bacteriology the surgeon may now penetrate any portion of the body without danger of infection, you will agree with me that if you are to be the individual to be operated upon, none but a trained surgical nurse shall touch you. Are you willing to have a twelve-week nurse prepare the sutures which are to be buried in your body; or will you trust yourself or your new born child to her ministrations? And yet I say to you frankly that the surgical nurse is the easiest of all trained nurses to prepare.

It is so easy to counsel a man with tuberculosis to stop work for six months, to lie in bed, to breathe fresh air and to partake freely of milk and eggs. But who is going to see to the carrying out of these instructions, especially if the man is poor, and who will keep up his constantly sagging spirits? If you want to see hard work, watch the nurse who understandingly takes care of such a patient. Or watch her as she works through the

*Read at the Cincinnati Health Exposition, October 18, 1921.

minutes which seem like days to the man with pneumonia. To inspirit a dying man to a last fight takes all of hand and heart and soul that the best of women can give.

There is not a feature of the sick room problem that can be solved by sending into it a half-baked simpleton and calling her a nurse. Even the generous heart is not enough. Grandmothers are still willing to tend the younger generation in labor; and if you think cheap service adequate, there are still midwives to be got for ten dollars. But if you want to know how labor pains have been stilled, (Why is it that husbands no longer lie in the ground surrounded by six wives each dead with childbed fever?) do not ask about the contributions which these, mayhap, good women have made to the subjects of anesthesia, bacteriology and surgical technique.

Must Increase Use of Hospitals

When it is contended that the worker cannot meet the financial obligations of adequate nursing service, I reply that the answer to one economic outrage is not another one. If we are already sweating the worker, let us recall our American standards and not begin to sweat the trained nurse also. As a matter of fact, ideas and movements are already active within the trained nurse group which can bring adequate nursing care to all our ill. Something like 90 per cent of nursing is now done outside the hospitals. We might begin by increasing the 10 per cent fraction and decreasing the ninety. Concentration within hospitals would mean not only better care for patients, but cheaper. At least as large a fraction of our medical patients should get into hospitals as of our surgical. But a better efficiency needs to be brought into our hospitals. There is no reason why the basic cost per patient in a hospital should exceed that of a good hotel. Let someone with initiative and love for his fellowmen come forward and show a community how it should be done.

We can begin to meet the outside problem by producing a much larger number of private duty nurses. But we are not likely to increase their number by degrading their social, economic and intellectual standards. If the number of private duty nurses remains inadequate, we can expand the excellent ideas of the district nurse, the visiting nurse and the hourly nurse. If the cost even of these is too high for the average man, let us charge it back to those who are responsible for the condition of the poor. Let us determine whether it is individual, corporate or state. There is no reason why many nurses should not be paid directly out of the public account. A community has obligations to its sick not only when they are resident in a hospital but when confined within the four walls of their own homes. We can increase, too, the number of nurses available for actual care of the sick by reducing our present reduplicated administrative staffs. There is no reason why in this city a half dozen hospitals should be running a half dozen personally conducted training schools. The fundamental education of the nurses might be given in one school, with the bedside and operating room work in the individual hospitals concerned.

There stands, in Waterloo Place at the foot of Regent St., near Trafalgar Square in London a great monument to the men who fell for England in the Crimean War. After its erection, that monument was pushed back to give space before it to a single small figure in bronze. It is the figure of Florence Nightingale. I do not suppose that the British Government would have moved that monument if it had not felt that the work of Florence Nightingale is more significant than the 1856 Treaty of Paris. It is to knock down this figure of the woman who beat the Russians more effectively than the British army and to put in her place a good woman, perhaps, but one of no education, no character and no human understanding, that some would have us accomplish. I think that it will not be done.

SHRINERS WILL ERECT TEN HOSPITALS

What is undoubtedly the most comprehensive program for the care and treatment of crippled children ever undertaken by any fraternal order is the project of the Ancient Arabic Order Nobles of the Mystic Shrine of North America for the immediate construction of five orthopedic hospitals in various sections of the country and for the future establishment of five additional hospitals, each to be erected at the estimated cost of $250,000.

The Shriners' original plan, in assuming paternal relations with the crippled children of the country, was to erect at St. Louis a central hospital of 150 beds in conjunction with Washington University. A survey of their prospective clientele brought results that astounded the Thirty-second Degree Masons. They learned that there are in America approximately 480,000 crippled children, one-half of whom might reasonably be expected to come within their constituency. With a single hospital of 150 beds, the trustees of the Shrine hospital program made hurried mental calculations and saw that to treat such a multitude of cripples would require something near 190 years.

Faced by the enormity of their task, the Shriners determined to continue their plans for the St. Louis institution on a lesser scale and to build as many smaller hospitals in other sections of the country as the money available would finance. The Shrine building program, as decided upon in late September, calls for the immediate construction of hospitals in the following cities:

St. Louis, an eighty bed hospital, for which $150,000 is allowed for grounds; $300,000 for buildings; and $50,000 for equipment.

San Francisco, a fifty bed hospital to cost not more than $250,000 when fully equipped.

Shreveport, La., a $250,000 institution.

Montreal, Canada, a fifty bed unit at $250,000.

St. Paul and Minneapolis, a similar institution.

The secondary building program of the order, to be undertaken as quickly as funds are available, calls for the establishment of fifty bed type of institution at Portland, Ore., one in some city in New England, Virginia, Pennsylvania and the Rocky Mountain states. The first one of these hospitals will probably be begun in 1922. Work on the five original hospitals will be well under way within a few months.

The one-story type of building, much in use for orthopedic hospitals for children, has been decided upon by the Shrine hospital trustees. Administration buildings of each unit will be the Moorish type of architecture with wards on either side in a design that will identify them at a glance as a Shrine center of interest. Shrubbery and flower beds on the grounds will be arranged to represent Shrine emblems, according to the plans, but the trustees are said to be anxious that efficiency will not be sacrificed for ornamental architecture.

Trustees of the hospital program are: Sam P. Cochran of Dallas, Tex.; W. Freedland Kendrick of Philadelphia, Pa.; Dr. Oscar M. Lanstrum, Helena, Mont.; Bishop Frederic W. Keator of Tacoma, Wash. John D. McGilvray of San Francisco, Cal.; Philip D. Gordon of Montreal, Can.; Forrest Adair of Atlanta, Ga.

REDUCING NOISE TO THE MINIMUM

IT IS a fact which most hospital people must know, but unfortunately few stop to think about, that the noise of the modern structure with its reinforced concrete and steel construction is one of the most trying of hospital problems today. It is absolutely necessary to bring interior disturbances down to a minimum. Mr. Frank E. Chapman, superintendent of Mount Sinai Hospital, Cleveland, Ohio, found that when standing in the proper place on the first floor of a modern building one can hear the nurses' call buzzer sound on the third and fourth floors. Imagine what the slamming of doors, the dropping of dishes, and the heavy tread of feet in the corridors must mean, in the aggregate, to the sick person!

Mount Sinai Hospital had tried, it thought, every means of conquering the noise horror. It had "reprimanded, dismissed, suspended, discussed, and cussed," without result. Finally someone conceived the truly brilliant idea of popularizing the idea by forming a "Society for the Prevention of Needless Noise." The society issued a number of bulletins, some of which are reproduced here, and also appointed monitors whose duty it was to "quiet all unnecessary noise in as diplomatic a manner as possible, making report of the most flagrant cases." They turned in a daily report on a regular form which provided place for the recording of the time, place, and character of the offense, the name and the "response" of the offender. The individual was to be approached by a tap on the shoulder and the courteous reminder, "Remember our guests."

The plan worked like a charm. The monitors and bulletins were far more successful than it had been believed possible. Of course, noise has not been eliminated from the hospital, but it has been reduced to such an extent that as one client of the hospital remarked, "You wouldn't believe it is the same place."

It has been necessary to re-issue one or two of the bulletins from time to time as a reminder, but they have always met with good response. There is no question but that the society is a success; would it not be well to form such a one in your hospital?

BULLETIN No. 3

A woodpecker pecks
Out a great many specks
Of sawdust
When building a hut;
He works like a nigger
To make the hole bigger
He's sore if
His cutter won't cut.
He don't bother with plans
Of cheap artisans,
But there's one thing
Can rightly be said:
The whole excavation
Has this explanation—
He builds it
By
Using
His
Head

Use your *HEAD;* hold your *TONGUE,* and make Mount Sinai a *QUIET* Hospital, in which to get *WELL.*

BULLETIN No. 6

RUBBER HEELS

We have no stock in the rubber business, but we place great deal of stock in rubber heels. *GET INTO A PAIR* and they will act as shock absorbers both to you and the ears of our guests.

BULLETIN No. 9

Supplementing the system of monitors now in effect, we are asking *EACH OF YOU* to serve as a committee of one in an attempt to reach a very small percentage of members and frequenters of our Institution who have not yet been reached by the "Gospel of Quiet."

You know some folks have to be lifted, like so many pieces of pig-iron. Their attitude towards our Campaign is just like the "darn-you-make-me-smile" spirit which they take to a comedy at the theater.

Please make it your business to go to these folks whenever they make Needless Noise and if they do not understand what "please-be-considerate-of-our-guests" means, just kick them on the shins and say, "*Where d'you get that stuff—don't you know you're in a hospital?*"

BULLETIN No. 5

The vogue of the Sinclair Lewis novel is recognition that his "Main Street" runs through thousands of American towns.

Stereotyped uniformity as the movement for standardization of good hospital methods grows and develops, tends to make each hospital the exact picture of every other hospital.

The only way to breathe the fresh air of individualism is to *EXCEL,*—to be the *BEST.*

Mount Sinai has the reputation for being the BEST in many ways and we have now reached the place where we are as good as the best in the elimination of "Needless Noise." Let us now put the "PUNCH" into our Silence Campaign in spite of Prohibition and become "The Hospital where Needless Noise does not Exist."

PUT THESE WORDS TO MUSIC AND SEE HOW YOU LIKE IT.

BULLETIN No. 11

"THE WORST BLOW TO PROGRESS WOULD BE TO SACRIFICE THE PROGRESS OF THE PAST"

When Johnnie was asked to leave a note where Mr. Jones would be sure to get it, he stuck a pin through it and laid it on the seat of Mr. Jones' chair.

We have fulfilled our purpose as the Society for the Prevention of Needless Noise, and with this issue, will suspend the publication of bulletins for the present.

Please consider this bulletin left for you just as Johnnie left the note for Mr. Jones.

If the future should necessitate a reminder for *you,* to "please-be-considerate-of-our-guests," will you be good enough to drag out this bulletin, read the first paragraph and "THINK IT OVER"?

AU REVOIR.

OVERCOMING DIFFICULTIES AT A SMALL HOSPITAL

By F. S. WRIGHT, M.D., Bellaire, Ohio

IN OCTOBER, 1916, in the City of Bellaire, Belmont County, Ohio, a municipality of approximately 16,000 inhabitants, the Bellaire City Hospital of fifty beds was completed and opened for the reception of patients.

Due to the large number of industrial accidents and the necessity of transportation of the seriously injured to the nearest hospital six miles distant, over rough roads, the public realized that a hospital was an essential adjunct to the community and the money necessary to erect and start in operation such an institution was raised almost entirely from individual subscriptions. With the opening of the institution however, a debt had developed and has remained to the present time.

Could Not Employ Proper Personnel

The development of the deficit in funds curtailed to a great extent the employment of an administrative personnel, competent in every way of building up the institution from the beginning, many obstacles have been encountered which seemed almost insurmountable.

This being the first institution of its kind, the public, in-so-far as they had furnished the financial backing, felt that they were entitled to perfect freedom as regards the institution, feeling free to visit patients at any time of day and night, demanding their presence at surgical procedures, criticising the treatment of the medical and nursing personnel, and in many ways hindering to such an extent the efforts on behalf of the board of trustees, the administrative personnel, the nursing staff and the visiting physicians and surgeons that the morale of these latter bodies was naturally lowered. This was true to such a degree that a reaction on behalf of the patients and a consequent inevitable reaction on behalf of the general public against the institution followed.

This sentiment reached a climax during the war and the epidemic of influenza, when every available space, including nurses' quarters, was utilized for patients. Due to the lack of trained nurses, volunteers did most of the nursing and were allowed free access to the institution, as a result of which scientific treatment and nursing was an impossibility. Control by the administrative personnel and board of trustees was lost to a great extent, all of which was found to react on the most important factor in an institution—the patient—and incidentally following this public opinion was decided against the hospital.

Stood Outside Looking In

During 1920 the board of trustees and the attending physicians and surgeons, realizing the defects of the institution and the "poor hospital service of same," and realizing as Dr. Warner says, that "There is no gain in having everybody outside the institution see the defects," proceeded to look at the institution as others were looking at it, and talk about it with others. Summing up the result of knowledge obtained with the past personal experience it was decided that radical changes must be brought about. An attempt was made to establish a "line of communication" with other institutions so that their policies and methods could be investigated and a future course mapped out.

One of the essentials learned was that there must be an administrative head of the institution, one capable of finding out its real problems, capable of keeping himself and the hospital informed, out of the rut, up-to-date, and efficient—no matter what difficulties beset them; and also that a large amount of brain energy and effort was absolutely necessary.

Proper Superintendent Obtained

In January, 1921, such an administrative head was obtained, and in due time properly trained and competent professional and other attendants have followed. Lines of communication have been established with the American Hospital Association, and the American College of Surgeons, and I might say at this time that one of the greatest stimulations to the board of trustees and the visiting physicians and surgeons for developing efficiency was the visit of the representatives from these organizations who pointed out the defects and the great importance of rectifying them.

Shortly after this time the West Virginia State Sectional Meeting of the American College of Surgeons was held in a near-by city and a large proportion of the board of trustees and staff of the institution attended these meetings; and as a result of knowledge obtained there, and the efficient administration of the superintendent, the result has been that a nurses' home has been obtained, equipped and placed in running order, giving the necessary things as required for the health, comfort and efficiency of the nursing staff, together with facilities for teaching. An x-ray laboratory has been equipped and developed to care for all fluoroscopic and photographic work (financially backed by the visiting physicians and surgeons until self supporting). At the date of this writing a general laboratory is in the process of construction and should be in operation within two months' time, capable of studying bacterological, serological and pathological material together with all routine laboratory analysis.

In April, 1921, the physicians and surgeons working in the institution organized as an open staff and since April monthly staff meetings have been held.

In order to enlist the confidence and interest of the public a pre-natal and pre-school age clinic will shortly be held at the hospital.

To summarize the difficulties of constructing and starting in operation a small hospital, establishing and maintaining "The Minimum Standard," would say:

(1) The development of an overhanging debt at the beginning, this debt curtailing the employment of efficient administrative personnel.

(2) Difficulty in obtaining pupil nurses, necessitating large salaries for trained ones.

(3) Lack of cooperation of all immediately connected.

(4) Difficulty in obtaining and holding public support.

COUNTY SHIFTS BURDEN TO STATE

It seems to be a general practice, in communities where the state's care of its wards is better than the care given by the county to its indigent population, for the county to shift part of its burden onto the state. It commits individuals not because they are insane but because they are sick or troublesome, or the proper medical equipment is not at hand. This may be right from a humanitarian standpoint, but it overtaxes the institutions of the state, and tends to a deterioration in state service.

IS THE ADMINISTRATION OF ANESTHETICS A ROUTINE PROCEDURE?

Whether any nurse or doctor, or even an intelligent layman with certain fundamental instruction, can administer anesthetic agents satisfactorily, has been the subject of much comment following the recent report of the Ohio Committee of Anesthesia. The committee, which was appointed by the council of the Ohio State Medical Association, answered the question in the affirmative and its action was later repudiated by the Ohio association through its House of Delegates.

Three men of note in the medical profession have added their views on the question to those published in the September issue of THE MODERN HOSPITAL. *Two of the three stand with the Ohio State Medical Association in opposing the nurse or lay anesthetist and the third believes with the committee that the procedure may be regarded as routine.*—EDITOR.

THE report of the Ohio Committee on Anesthesia does not find support in Dr. Paluel J. Flagg of New York City who thinks that this department will accomplish nothing in the way of scientific research and discovery so long as it is under lay control. He writes:

Nurse Anesthesia Not Ideal

"Teaching clinics are expected to provide ideals for the remainder of the profession to follow. Nurse anesthesia is not ideal and never can become so.

"The profession looks to the large clinic for the best in every sphere of medical activity. This is found, as a rule, with the single exception of the Department of Anesthesia. The anesthetic technician which visitors observe sets the pace for the anesthesia administered elsewhere. The result is the relegation of anesthesia to the hands of the suburban nurse whose experience is almost nothing and whose confidence is unlimited.

"A department of anesthesia under lay control is, by the very nature of its personnel, incapable of scientific research and discovery. The clinic surgeons and housemen have had no experience in the administration of anesthetics and consequently have no practical judgment to pass on the anesthesia which is administered for them. Indeed, they cannot afford to lose caste among their fellows by showing too much interest in work which a nurse is expected to perform to every satisfaction.

"The recent enthusiasm for local, spinal and regional anesthesia in some clinics would appear to be a formal acknowledgment of the shortcomings of the general anesthesia available where anesthesia is administered by non-medical persons.

"However opposed one's views are regarding the qualifications necessary to enable one to administer anesthetics, there is no necessity whatever of allowing the matter to lose its academic dignity and to confuse the issue, 'which is, and must ever be, the ultimate good of the patient.' 'The friction of men's minds, not men's passions, makes the sparks of truth to scintillate.' Indeed, one of the pleasantest occasions which the writer ever experienced was spent with a charming young lady anesthetist who called to ask for a few directions as to how to give ether. For two hours we talked of everything from Texas steers to chop suey, anesthesia having proved a bit technical after the first two minutes."

From Dr. A. B. Denison, assistant director the Lakeside Hospital at Cleveland, comes the following opinion:

Must Not Divide Responsibility

"In general, my ideas regarding the administration of anesthetics coincide with those of the Ohio Committee on Anesthesia of the State Medical Association.

"The basis of my thinking this is primarily the fact that under all circumstances the anesthetic and the person administering the anesthetic are the responsibility of the operating surgeon and that this responsibility cannot be delegated to another person. It seems to me that this is exactly parallel with the responsibility of the surgeon for his assistant in the operation and it also seems reasonable to assume that the anesthetist is an assistant of the surgeon.

"I believe, also, that the surgeon performing the operation can, at all times, give a perfectly competent appreciation of the state of the anesthetic from the general behavior of the patient and, since this is true, it seems that the surgeon could conceivably manage the anesthetic as well as the operation. Under these circumstances, the administration of the anesthetic does become a routine procedure which could be administered by anyone having a reasonable amount of instruction in the administration of anesthetics."

Dr. William L. Soule, anesthetist of the Cornell Division of the New York Hospital, strongly advocates the administration of anesthesia by specially trained doctors. He writes as follows:

"Learning that you have in view a symposium on anesthesia and anesthetists, with special reference to the report of the Ohio Committee, I take this opportunity to relieve my mind of a few thoughts and opinions.

"According to the Journal of the A. M. A., 'the committee regards the administrations of anesthetic agents as being almost entirely a routine procedure and something which can be done by any intelligent physician or nurse, even by a layman who has had a reasonable amount of instruction in their administration.'

"Just Pour on the Ether"

"This position reminds me of the remark made by a certain house surgeon, when I spoke of teaching a junior intern to give anesthetics. He said: 'I didn't know anyone had to be taught to give an anesthetic. I thought you just placed the mask over the patient's face and poured on the ether.' To one who has been through the agonies of learning to give anesthetics properly and is constantly instructing others in the art, such views of course seem absurd, and the fact that they are held, in a modified form, perhaps, by so many who ought to know better is not flattering or encouraging to those who would like to see anesthesia placed on a better footing. To be sure, ether is almost fool-proof, and gas and chloroform, while more dangerous, have really a very low mortality, so that *nearly* every patient survives even an atrocious anesthesia. Subsequent complications are due to so many causes, that, with the exception of conjunctivitis and the aspiration of foreign bodies, it is difficult to say positively what ones the anesthesia is responsible for.

"The fact that so many anesthesia are badly conducted is proof in itself that their proper handling requires a high degree of skill. To put the patient to sleep hu-

manely rather than cruelly, to bring about sufficient relaxation, with a minimum of the toxic drug, to maintain an approximately normal color, above all, to judge accurately the depth of narcosis and the patient's condition—these are accomplishments which depend on sound training and long experience. Even then, one sometimes meets with a case which baffles his best efforts, and strikes his self-esteem a crushing blow.

Doctors Not Interested

"The question, 'Should a nurse give anesthetics?' may be answered by the question, 'Should a nurse attend confinement cases?' In all probability a nurse with six months' good training could take care of a normal labor case as well as the average general practitioner, perhaps as well as a specialist. In fact, the midwife is a recognized institution in some countries, and is not unknown in our own. Practically every intelligent woman, however, expects, as a matter of course, to be attended in her confinement by a medical man or woman, and there is an ample supply of such to choose from, except in the smaller towns, where the choice is more limited. As far as I am aware there is no movement in existence in favor of employing nurse obstetricians.

"With the nurse anesthetist, the case is different. The main reason for her existence is the fact that so many of both profession and laity are satisfied with her. Even those of us who object to her are forced to admit that she is, to a certain extent, a necessary evil. In New York City, for example, if all the nurse anesthetists were to go on a strike it is doubtful if competent members of the medical profession could be found to take their places permanently, except for a higher remuneration than the hospital can or will afford.

In the future conditions may change, and the nurse anesthetist gradually go the way of the midwife. Her retirement, however, is delayed by the reluctance of promising young doctors to take up so narrow a specialty as anesthesia, and by the strong bias in her favor on the part of certain members of the profession in high standing."

FOCH AT HOSPITAL DEDICATION

Dedicatory exercises at the Edward Hines, Jr.. Hospital at Broadview, Ill., took place Sunday, November 6, with Marshal Foch, generalissimo of the allied armies, as guest of honor. The dedication was in charge of the American Legion, with State Commander W. R. McCauley of Illinois presiding and with National Commander Hanford MacNider among the speakers.

Marshal Foch unveiled the portrait in oil of Lieutenant Hines, who died in France while in the service of his country. Two flags, the French tricolor and the American stars and stripes, draped the gold frame of the picture, which hangs in the administration building of the hospital.

At a spot on the spacious grounds of the government hospital, ceremonies took place while above the platform aviators circled and dropped flowers.

Miss Margaret Anglin, the actress, dramatically recited in French a poem by Jules Bois as a part of the program. Addresses were then made by the national and state commanders of the American Legion, by Senator Medill McCormick of Illinois, and finally Marshal Ferdinand Foch of France was presented. The marshal did not speak, but following the exercises made a tour of inspection of the hospital, where he patted the heads of many patients and addressed cheering words to them in French.

"The marshal wishes to say," said his interpreter to the disabled veterans, "that he is glad to be with you and remembers the days when he was with you on the other side. When he called on you for something then, you did it, and if there is anything he can do for you now, he will do it." Marshal Foch also greeted Chief Nurse Mona Charles, whom he had met in Chalons while she was on active duty.

LIBRARY HAS GUESTS FROM HOLLAND

Dr. William Vos, superintendent of the municipal Zuider Ziekenhuis (Southern Hospital) and Geneesheer-Directeur van de Psychiatrische Inrichting Maasoord der Gemeente, and Mr. Jan G. Snuif, architect, both of Rotterdam, Holland, visited the Hospital Library and Service Bureau in Chicago November 1. The Maasoord is a hospital of nervous and mental diseases. These gentlemen have recently come to this country to study hospitals and have spent some time in Boston, New York, Buffalo, Cleveland, Detroit, Chicago, Rochester, Minn., and will then stop in Cincinnati, back to New York and home to Holland. They are planning to build a new hospital in Rotterdam of approximately 1,300 beds. Their old hospital was built in 1850 and is now the oldest hospital in that country. The new hospital will care for practically all types of cases save pediatric, since there are two other hospitals in Rotterdam which care exclusively for children.

JOURNAL APPEARS UNDER NEW TITLE

Announcement has been made of the change in title of the British journal, *The Hospital*, to *The Hospital and Health Review*. The first issue of the journal under its new name is now from the press. The purpose of the change in title, as given by its publishers, is to make its material not only of appeal to those interested in the hospital and in public health services but to reach "everyone who realizes the importance of the teaching and practice of health and who has grasped to its fullest significance the old proverb, 'Prevention is better than cure.' "

With the beginning of the new series, the magazine announces that it will include within its sphere the various aspects of public and personal health, preventive and curative medicine, and the general well-being of the people.

COLORADO BECOMES BRANCH OF A. H. A.

With the recognition of the Colorado Hospital Association as a branch of the American Hospital Association at the West Baden conference, the fifth geographical section of the national organization has been formed. Officers of the Colorado association, to which 226 hospitals are eligible for membership, are: President, Dr. Richard W. Corwin, chief surgeon, Minnequa Hospital, Pueblo; vice-president, George Holden of Denver; and executive secretary, Pliny Clark. Three meetings are to be held annually.

TRUSTEES' SECTION FORMED

The trustees of the American Hospital Association at the close of the West Baden conference voted that a section be formed for the discussion of hospital problems within the scope of the function of trustees. The conference next year will have such a section. Fifteen trustees attended the 1921 conference.

WHERE TO GO FOR MONEY IN ORGANIZED WORK FOR THE SICK *

By RICHARD M. BRADLEY Trustee, Thomas Thompson Trust, Boston, Mass

Where should the hospital go for money? To the consumer, says Mr. Bradley. "It is about time for us to undertake to 'sell' the necessary organized service, nursing, hospital, and otherwise to the consumer, and not to somebody else, and to undertake to do this on sound business and financial lines suited to the needs and nature of emergency service. The financial and business failure of our so-called system is not that of the professional workers in their own proper field, but of the business and financial men connected with this work who are failing to give it their business brains. It is a strange phenomenon that these men, in this connection, pursue methods that, as business and financial methods for accomplishing the purposes intended, are unworthy of comparison with the lowest standards of any other field of business efforts. They give their business brains to other things and reserve their emotions for hospitals."

THE organized service which the general public requires in connection with sickness and maternity has of late years been found to cover more and more new fields of effort, and has been found to require for its satisfactory accomplishment an increasing amount of specialized work, often involving expensive building and equipment, and calling for a continually enlarging personnel of workers.

While from these causes there comes an imperative call for much new money, at the same time the old work is costing much more than ever before. Meanwhile the supporters of our hospital and nursing work find their funds reduced by high taxation and business reaction, and are subjected to additional calls for assistance from all quarters of the world.

It is not to be wondered at that many old and tried institutions are finding it hard to carry on. Simultaneously with all this, an awakened public interest is finding itself deeply and fundamentally dissatisfied with much of this service as it has existed in the past, both because the service they have learned to want is insufficient and because of its charitable character. We therefore hear calls for state subsidies, state insurance, and public control of work that has hitherto been left to individual workers, or to self-perpetuating privately controlled philanthropic bodies.

This dissatisfaction may be encouraged by demagogues and self-seekers, but it has a real basis in defects that are only too manifest.

A house to house canvass of a cross section of the people taken almost anywhere in country or city, showing what has actually happened to the people in sickness and maternity, will convince the most skeptical that there is a radical maladjustment between the people and the service that they should get, and that the machinery for getting the people to the service and the service to the people is not working satisfactorily.

Moreover, no one who has realized the honest repugnance felt by the ordinary plain citizen for the charitable or semi-charitable methods connected with much of the only organized help available, can doubt the sincerity of those who are calling for something different and better.

We can sum up these complaints by saying that while technique is constantly being bettered and individual work in medicine, surgery and nursing is constantly improving, the application to the people of the knowledge and skill thus acquired is failing in efficiency.

This state of affairs is bringing a call for various remedies that are probably worse than the disease, and before we drift further into perilous waters, may it not be well for us to ask ourselves whether this palpable failure of satisfactory accomplishment in what is one of the most important fields of human effort, is due to the peculiar nature of the work or to our own present methods of trying to accomplish that work.

Why is it that the great and important industry of caring for sickness and maternity should be in such a condition of unsatisfactory accomplishment, and of financial distress, that government operation and resort to the tax payer should, to many persons, present an attractive short cut to better things?

Why should this be the case when not only are our public health officers fully occupied with the enlarged duties of their original field, but the public has just become pretty well convinced that in almost all other lines of human enterprise the extension of government effort is to be avoided wherever possible? Why is private enterprise in this particular field so inadequate, and so embarrassed financially that increased government work is urged as a desirable alternative?

It is my conviction after a long experience in trying to get things done by organized service for the sick, that this failure is not due to the peculiar nature of the service to be done, but to the peculiarly unsound way in which it is being done on its financial and business side. We have here what would be an absurdity were it not too often tragic in its results. We see a rich nation needing to have done a large amount of service, in connection with sickness and maternity. This work is perhaps the most important of all human services. It is a service that the nation evidently cannot afford not to have done; yet that service is being done in a most insufficient manner. We hear constant complaints that there is not enough money for it, while at the same time vastly greater amounts of money are being drawn from the pockets of the people for amusements, luxuries, and other things that are comparatively of little importance.

While technical efficiency in medicine, surgery and nursing is constantly increasing, we see for whole sections of the population the application of that improved service to actual cases becoming less and less efficient, while for other large portions of the people progress is fatally slow in getting the service to the cases, or the cases to the service.

In this state of affairs we hear the call for two chief remedies, namely, a more extended resort to the government and to the tax payer, and greater contributions from the philanthropist.

Consumer Should Pay for Service

It is my suggestion that for a large portion of this problem neither of these methods is the true way out, and

* Read at the Twenty-third Annual Conference of the American Hospital Association, West Baden, Sept. 12-16, 1921.

that the true way out is what has proved the normal, ordinary, and effective way for nearly every other organized effort to serve the public's needs.

That way is to expect financial support from the consumer, or, in other words, to offer the person to be served the service that he needs in such a form that he can pay for it, and to require him to pay for it.

To use a common business expression, it is about time for us to undertake to "sell" the necessary organized service, nursing, hospital, and otherwise, to the consumer, and not to somebody else, and to undertake to do this on sound business and financial lines suited to the needs and nature of emergency service.

The financial and business failure of our so-called system is not that of the professional workers in their own proper field, but of the business and financial men connected with this work who are failing to give it their business brains. It is a strange phenomenon that these men in this connection, pursue methods that, as business and financial methods for accomplishing the purposes intended, are unworthy of comparison with the lowest standards of any other field of business effort.

It is true that of late years there has been some progress in accounting and in administrative economics, though there is room for much more, but this is not the fundamental trouble.

That fundamental trouble has its origin in the fact that nursing and hospital work was originally organized to aid the pauper classes, and is still conducted with traditions and methods suited to the pauper and not to the people. These pauper classes were in former days regarded as a large and necessary part of every properly constituted community, and their existence, in the eyes of many good and devout people, was supposed to be called for by a sort of divine decree, declaring that poverty and dependence are a necessary factor in the production of benevolence.

Pauper Class May Be Made Small Part of Whole

The study of social science, and a more enlightened social and industrial system, has brought us to see that in this country at least this dependent class can be reduced to a comparatively small proportion of the whole, and it is neither necessary nor desirable to make that class a determining factor in the organized service of the sick. Old ideas, however, die hard, and the idea still holds sway that in connection with this work we are justified in the unnecessary infliction of benevolence upon our fellow beings, which act I sincerely hope will sometime be promoted to its proper place among the deadly sins since it is as bad morally as it is financially.

At the root of our inefficiency is this medieval idea that charity is a controlling factor in organized therapeutics, together with the idea that the service of the sick and suffering, or of the helpless mother and child is something so important and so appealing that the application of ordinary business method and common sense to its relief is a profanation.

I read only yesterday of some "big hearted man" who had endowed a great specialized hospital where none but those unable to pay were to be admitted, as if disease and suffering were an exclusive possession of poverty, and as if his self-supporting fellow citizens had no need of high organized service. The foundation provisions of some of our oldest hospitals are permeated with this same error, which has sapped their vitality and limited their usefulness to an untold extent. This provision of hospital and nursing service exclusively, or primarily, for the pauper has been modified nowadays into the "pay what you feel like" method, which is erroneously supposed to dispel the atmosphere of pauperization, but largely fails in extending needed service to the independent classes. Morally, it is rather worse than the exclusively charitable method, because it is not straightforward; financially, it is also a failure.

Citizen Wants to Pay for What He Gets

Now what the ordinary citizen calls for is neither charity nor indulgence. What he needs and wants is a pay envelope or a salary check sufficient to meet his daily needs, with a sufficient margin for emergencies, and he needs to have his emergencies so financed that he can pay for them from that margin. He has full appreciation for the philanthropic endowment that makes possible the great school, university, or hospital, or nursing organization, with a high standard of service open to the people on equal terms, but when he takes that service he wishes to go to the hospital, or to the nursing service station, as well as to the school, or to the university, with his head up, and on the basis of self-respecting equality, with no favors asked.

What is it that is necessary in order to enable him to buy this service in this way? Simply the recognition that it is *emergency* service and that we must finance it accordingly on the benefit payment or insurance basis, as all such things must be financed if the ordinary consumer is to pay for them.

Disease and sickness are not expenses that come with regularity like taxes, rent and food. They strike here and there, but owing to the philanthropic fog that has clouded our financial intellects in this connection, we as a rule make no provision for that fact. If a salaried man or mechanic loses his house by fire and has no insurance, he is pitied for a fool by his neighbors, because they are educated to use fire insurance, but let him have two or three capital operations, or a severe epidemic in his family, and it is treated as an act of God, the probability of which apparently no human wisdom could possibly have foreseen. He must either partake of charity in some shape or suffer unassisted. There is no systematic effort to find out what it costs to give him this service and to offer him insurance against that cost. Yet such things are just as certain to occur as fire, and many of them are less preventable.

Sell It in Form of Benefit Payments

The way out for our own organized services, both nursing and hospital, if they would serve the whole people, is to put this emergency service of theirs into such shape that the people can pay for it; in other words, to sell it to the consumers, in the form of benefit payments for hospital and nursing service.

There is plenty of money in the country for repairing a broken down motor and there is good service for that purpose on nearly every corner, for the simple reason that those who furnish it are able to do so since they get themselves paid for it.

I respectfully suggest that the same principle be applied to broken down bodies, and that you get your trustees, and committees, to diminish the swelling of their philanthropic pride, and apply a small portion of their good business brains to getting more of your expenses paid by the consumer through benefit payments and proper financing for emergency work. Make them get to work and sell your hospitals, and your nursing, to your consumer in benefit payments. This is no pipe dream, it is done for nursing by the Metropolitan Insurance Company for some of the needs of our very poorest, out of their pockets. It has been done for years in some countries by nursing benefit payments for associate members that cut the ordinary fee in two for such members, at the

expense, one of the founders told me, equal to the cost of a couple of dozen or so drinks per man. The same thing can be done here, and it can be done just as well for many other emergencies, such as capital operations, with a still larger portion of the cost paid through benefit payments, for people don't indulge in capital operations, as they do in nursing, for the sake of mere comfort.

Don't let your trustees potter around trying to get a lot of elaborate statistics as a basis for benefit payments. Take a few hundred families and make up an offer of this emergency service that they will probably need, estimating its probable cost, as best you can, and make your trustees underwrite your guess. Get your system going and you will soon enough find where it comes out in practice. Don't worry if you don't get many buyers at first. Put your cost accountants at work and find out what is the reasonable cost of every piece of service you do, and charge for it. Show what it will cost with benefit payments and without. Then if there is trouble, you will be able to show what your benefit payments can do.

This kind of dealing with Mr. Ordinary Citizen will be better for his soul, and he will respect and like you all the better for it.

Special Funds for Real Dependents

Your real dependents who cannot pay benefits should be financed from special funds treating dependence rather than disease, in a way distinct from the independents, and incidentally you will find what are your parasite, underpaid industries whose sick employees come on the public charge. There will still be plenty of scope for your philanthropists in taking care of these dependents, if your benefactors are not interested in enabling high standard service for all. Incidentally, in furnishing better service for all, you will be able to furnish better service even for the paupers. There is more money for your work in the pockets of the people than anywhere else. Go after it.

I am aware that in what I have said I am addressing a body of very busy people, whose greatest interest is in things that are not financial. As a class, you attend to financial things only when you have to, and you do it merely because you are not able to do your work from lack of money.

This sermon I have tried to preach, like many other sermons, is needed most by the people who are not in church. Therefore I ask you to pass it on. It is needed by those important bodies—your trustees—who, as a class, don't attend hospital meetings, but give their business brains to other things, and reserve their philanthropic emotions for their hospitals. What is more needed by the hospitals, and other organizations for the sick, is their business brains, and therefore I am presenting you with this short discourse as a testimony of a business man, to the effect that it is the business side of your proposition that is weak, and that it behooves you to get the business side of your hospitals to sit up and pay attention to this subject.

You cannot, many of you, run hospitals and start a financial enterprise at the same time, but it is possible for you to get after the financial members of your board and present this testimony, to the effect that up to the present date their financial methods are not worthy of them, and because those methods are not up to ordinary business standards, their whole enterprise is threatened with failure.

Many of your trustees can sell almost anything to the people when they try, and they can sell them your hospitals, if they will take the time and trouble, for the goods in this case are worth more than the money they cost, and they have not even attempted to reach the real customer—the consumer. I take the liberty of advising you to tell them this and not to give them any peace until they really wake up and take hold of it.

CELEBRATES 150TH ANNIVERSARY

The Society of the New York Hospital, the second oldest institution of its kind in the United States, which received its royal charter in 1771 from King George the Third of England, celebrated its 150th anniversary in October. Commemoratory exercises took place in Trinity Church, where the hospital was founded, and were attended by more than 1,000 physicians, surgeons, nurses, the governors of the hospital and their friends. Gov. Nathan L. Miller, Elihu Root, Bishop William T. Manning and Edward W. Sheldon, president of the society, delivered addresses.

After a prayer by Bishop Manning, the ancient church building was turned over to the hospital, Mr. Sheldon presiding. An historical address on the hospital was made by Mr. Sheldon, who traced the activities of the institution from the day in 1769 when Dr. Samuel Bard, one of the distinguished physicians of the Colonial period, arose in Trinity Church at the graduating exercises of the medical school of King's College, now Columbia University, and made a strong appeal for the establishment of a public hospital in New York City, to the present day. Dr. Bard's suggestion was immediately followed by a collection, to which the governor of the Province of New York subscribed, and thus was started the hospital.

The hospital was completed, after a fire had previously destroyed it, just before the Revolutionary War broke out, Mr. Sheldon related, and shortly afterwards it was taken over by the British troops and used as a British hospital. He stressed the great work of Bard, Hosack, Willard Parker, Wright Post, Weir, William T. Bull and other physicians and surgeons on early staffs of the hospital.

In enumerating achievements of the institution, Mr. Sheldon spoke of the Dr. Valentine Seaman, who went to London at the time of Jenner's great discovery and returned immediately to New York, where he demonstrated for the first time the vaccination for small-pox. He related how one doctor, thirty years before Lister's great discovery, worked on a similar proposition at the New York Hospital and told of the many new operations that were recorded there. He said that the New York Hospital, during the eighteenth and nineteenth centuries had been the beacon from which all the United States received its medical and surgical light, and read extracts from reports of doctors made fifty and sixty years ago stating that it was the greatest medical school and center in the country.

The institution has treated 2,015,000 patients since it was founded, Mr. Sheldon declared, a much larger number than has been cared for by any other hospital in the country with the possible exception of the Pennsylvania Hospital in Philadelphia.

Governor Miller spoke on the great work being done at Bloomingdale Hospital and said that Bloomingdale had pointed the way for the state. He voiced approval of its occupational therapy department and declared that it was the foremost of its kind in the country.

Elihu Root, who closed the exercises, said that while the names of the doctors who were associated with the hospital even thirty and forty years ago are now forgotten, the hospital today is a living monument to their work and to that of all of those who have gone before.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Director, Department of Nursing Education, College for Women,
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PUTTING THE HOME TOUCH INTO THE CHRISTMAS OF THE STUDENT NURSE

Just how to send scurrying away into the dark regions from which they spring those consuming pangs of homesickness which beset the student nurse as the holiday season approaches is a problem which is being skillfully met in many hospitals to the great benefit in morale of nurse and, indirectly, patient. There may be much of tragedy in the student nurse's first Christmas away from home unless active preventive measures are taken.

The element of mystery and surprise which is so large a part of Christmas in the home may be preserved with success in formulating plans for the nurses' holidays. It may simply be pancakes for Christmas breakfast prepared by no less a personage than the principal herself, decked in chef's cap and apron and with a fetching daub of flour on her nose, as a student nurse at Lakeside Hospital in Cleveland, Ohio, relates in her account of 1920 holiday festivities. Or it may be the bringing of unexpected happiness to others, as was accomplished by the "Brownies" from the Chicago Presbyterian Hospital in their distribution of baskets of "goodies" to some unfortunate families.

The exchange of inexpensive and ridiculous gifts on Christmas Eve around a tree made glittering and gorgeous by their own hands, the lifting of their voices in unison in age-old carols, a quiet story-telling hour around the fire on Christmas night after a bounteous dinner has been served and letters dispatched home, a week's program of children's parties, minstrel shows and tally-ho rides by moonlight are pertinent suggestions sent to THE MODERN HOSPITAL *by student nurses themselves in an effort to assist their fellow students the country over in making Christmas time within hospital walls the joyous occasion it used to be when within the home circle.*

Some of the girls themselves in the following paragraphs give vivid accounts of the pleasures in which they took part.—EDITOR.

FROM Mt. Sinai Hospital, in Cleveland, Ohio, Miss Eva Milton writes a graphic story of her first Christmas away from home and how it was made a merry one:

All Eyes on Bulletin Board

"This was to be my first Christmas away from home. Oh! wasn't there some way to arrange for my going home? That question was uppermost in my mind. So far during my probationary period I had been very happy and not at all homesick, but now, Christmas was so near at hand—Christmas, the happiest and most eagerly anticipated holiday of the year, and I was not to be at home! Oh! I couldn't bear it. But, nevertheless, I went to work with grim determination and with the old fashioned thought that 'a nurse's life means sacrifice'—sacrifice of all merry-making, friends and in fact all that one normally enjoys.

"One day about a week before Christmas, as I hurried past the bulletin board on my way to lunch, I was attracted by a notice. Judging from the long list of nurses' signatures underneath, I thought it must be a petition for a Christmas vacation of a day or more. I was mistaken, however, for the notice read:

"'WILL THE NURSES WHO WOULD LIKE TO CELEBRATE CHRISTMAS EVE AS WE DID LAST YEAR SIGN BELOW?'

"'Last year'—yes—how well I remembered the Christmas Eve party at home! But Christmas here—I was doubtful. I reached for the pencil, however, added my name and proceeded to the dining room. Such chatter, everyone seemed to be talking at once. After listening for a while I learned that they were discussing the good time they had last year at Christmas. By the time luncheon was over I had quite forgotten about going home and was quite over my prejudice.

"What happy days followed! Everywhere the holiday spirit began to manifest itself. All faces registered contentment. Christmas parcels with the usual caution, 'Do not open until Christmas,' began to arrive. What delightful suspense! We probationers who were most likely to be homesick were asked to help with decorations. No attic, I'm sure, ever held more Christmas ornaments than ours brought forth and no trees could have been lovelier.

Back to Childhood Days

"Then came Christmas Eve. A 'children's' party was to be held in the recreation room. Much shortening of skirts and plaiting of braids took place in preparation for it. During the early part of the evening all the 'little' girls played games and danced. Later Santa Claus (one of the head nurses) was ushered in with his usual Christmas baggage. Every girl received a gift (several days before each one had drawn a name and purchased a twenty-five cent present for that person). Besides Santa's individual gifts there were other gifts for the nurses as a group. Several boxes of candy and magazine subscriptions were received from the staff doctors; from our own dear principal we received a col-

lection of Victrola records, including the latest song hits as well as classical music. The dietitian also had a surprise for us in the form of fruit, nuts and hard candies. The remainder of the evening was spent in dancing and singing. That evening as each little girl went reluctantly to her room I'm sure she felt that this was one of the happiest Christmas Eve parties she had ever attended.

"Five o'clock next morning—Christmas day. Our class had decided to awaken the faculty by singing Christmas carols. It was a delightful Christmas morning; the atmosphere seemed to have caught the spirit. Beaming faces and expressive 'Merry Christmas' were all about. As we sang we awakened the entire school and three-quarters of an hour later we had all assembled in the principal's office to make ready to sing to the patients. Formed in double file and carrying lighted candles, we marched through the wards singing all the old familiar Christmas carols. How impressive it was! Every nurse keenly enjoyed it. At 6:30 a. m. we went to the dining room, which had been decorated most fittingly, complete in every detail, even to the tree beautifully lighted with electric bulbs. The breakfast was a treat. Then after more singing of carols and school and class songs, a very happy group of nurses went on duty for half the day. At noon a bounteous dinner with all imaginable goodies was served.

"To complete our most enjoyable Christmas festivity, a formal Christmas dance was given a few evenings later by the school for the nurses and their friends, at the Masonic Temple nearby. This occasion, with elaborate decorations and an excellent orchestra, marked the climax.

"How ashamed I felt to think I should have doubted a happy Christmas! I feel sure that never before had an institution experienced a more delightful holiday spirit and more good will toward men."

Those in charge of the training school for nurses at Lakeside Hospital in Cleveland, Ohio, certainly believe that the Christmas holidays come around to be celebrated. Miss Evelyn Childs, a student nurse, tells of the holiday gaiety which pervaded those halls in the following:

Pancakes by New Chef

"Workaday Lakeside, pursuing her serious occupations, turns her holiday face to the world at Christmas time. No hospital students can play with more zest or work with greater zeal when duty hours demand than those at Lakeside. The happy spirit of fellowship and of service permeates the very air for several weeks before. The singing of Christmas hymns at the regular morning chapel helps to foster the spirit.

Nurses begin early to decorate the wards, and each head nurse tries to have her plans a surprise for her fellow workers, who tell little of the secrets enclosed in their cupboards. A general feature of each ward decoration is a large Christmas tree with its tinsel, candy, and popcorn festoons. Then, too, can be seen fireplaces with the time-honored stockings, while lanterns, wreaths and shades add to the colorful scheme. Nor is the nurses' home forgotten. The living room, class rooms, and halls each has a share in the festivities; in individual rooms quite original decorations are seen. In several rooms last year were small trees which were lighted on Christmas Eve.

"Another pleasure, begun several weeks before Christmas, is the carol practice, led by Mr. Kraft of Trinity Cathedral. Last year, Christmas morning dawned for us at 4:30 a. m. The nurses were awakened by a bell sounding on every floor, and hurriedly and happily they assembled to start on their round through every part of the hospital to sing carols. The procession, headed by a nurse with small portable organ, was made more effective by the lighted candles. Two student nurses sang a duet. For once the patients made no complaint for having been awakened very, very early.

"On Christmas Eve we felt a secret was in store for us, but no one could guess its nature, however hard she tried. Upon returning from the hospital after the carols, a poster on the bulletin board led us by arrows to the surprise. The poster read: 'NEW COOK MAY BE EMPLOYED BY OFFERING HIGH WAGES. PANCAKES A SPECIALTY.' And whom should we find to be our new cook but our principal, Miss Allison, arrayed in a baker's cap and apron, baking pancakes for the student government council, which had been invited to have breakfast in the new kitchenette. The kitchenette was opened Christmas morning, fully equipped for the use of all the nurses. Pancakes for breakfast! It was a treat, indeed. They were enjoyed by all the nurses in their respective dining rooms.

Santa Visits the Children

"Soon the call for duty came, and the nurses assumed their morning work, happy in their patients' joy over the gifts which the Christmas trees bore for them. Later in the morning, as many nurses as could be spared from their floors went to see the Christmas tree on the Children's Ward. Santa Claus was there in person and he brought each child what he or she had wished for most. Happy was the day for the little patients!

"For the nurses who spent the day at the hospital, there was an especially good dinner, and in the evening a buffet luncheon was served in the living room of the nurses' home. To this the doctors and outside friends were invited, and it was followed by dancing. Finally the nurses and guests, seated in the living room, aglow from the grate fire, were surprised by Santa Claus, who arrived shaking the snow from his pack. The Christmas tree in the corner was laden with gifts, and these were distributed by Santa to each nurse, each gift being chosen as appropriate for the recipient, and usually not exceeding ten cents in cost.

"The following week was one of parties and gaiety. Each class selected an evening in which to entertain the rest of the students. Among these was a 'Last Day of School,' for which everyone dressed in her best, and 'spoke her piece' with pride but timidity. A minstrel show was successful, with its orchestra composed of members of the junior class. Other evenings were equally enjoyable, and the week ended with a pleasant memory on the part of the students, who, far from home, could wish for no happier holiday season than that at Lakeside at Christmas time."

Miss Gwyneath Porter was a student nurse at the Presbyterian Hospital in Chicago last year and she gives in the following words a touch of the holiday atmosphere as she felt it while on night duty:

Night Duty on Christmas Eve

"Who has not had a desire in childhood—if not in later years—to stay up all Christmas Eve and watch Santa come down the chimney, and see all the other things generally supposed to happen on that eventful night?

"I must confess that enough of my childish illusions remain to make the fulfilling of such a desire quite a delightful prospect. So it was with an inward feeling of 'something going to happen' that I went on duty at 11 o'clock that Christmas Eve. The air was crisp and cold and the blue-black sky, studded with twinkling stars, seemed to whisper peace and good will to the sleeping

city. In the wards all was dark, yet as I made the rounds I was aware of decorations and miniature Christmas trees which had been prepared during the day. A quiet night it was, for the patients slept well, so while I sat and made dressings I had time to think of the Christmases that had passed and of the joy that the Christmas season brought to the world.

"It was about three in the morning—just the time when sleep is nearest to getting the best of one on night duty,—when I went to the serving kitchen to heat some milk for a patient. Oh! how shall I describe the awful sinking feeling at what met my sight! A beautiful sea green sink persistently overflowing itself onto the floor, which already lay covered an inch deep in water! Behold me, my sleepiness drowned in dismay, mopping as I have never mopped in my life before! And not till half the floor was dry, did I even think how funny I looked mopping so early on a Christmas morning. I 'phoned to the nurse's office in case some damage might be done to the floor below, and presently up came the night superintendent. Other nurses will appreciate the kindness of the remark she made, 'Never mind, it will be dried before daylight, and a nurse's training does not seem complete without some such experience.'

The Hospital Family Awakes

"Before I knew it, daylight was sifting in through the windows and doors, and I felt as I imagine many a mother does as I wakened my family and wished them a Merry Christmas, while they washed. Then across the court and up through the stairway came the voices of the day nurses as they sang Christmas carols from ward to ward.

"Excitement reigned, for were they all not going to have special diet orders for that one day calculated to include as many as possible of the items on the menus of the "honest-to-goodness" Christmas dinner! Then there were letters and cards and boxes of candy and presence till bedside tables could hardly accommodate the array.

"Then home to breakfast. It is the custom in our school that there should be a special surprise planned by the housekeeper for that meal. This year it was in the form of rosy apples whose cores had been removed and in whose place grew fat red lighted candles. Sleep seemed well nigh impossible on such a day, but tired nerves must be pacified so a few short hours were spent in bed. Noon brought everyone together to a beautifully served and 'scrumptious' Christmas dinner.

Entertain in Sun Parlor

"An afternoon party was in progress in the sun-parlor on the roof at which some of the faculty entertained all the nurses remaining at home. Evening came, and to end up the day an entertainment had been planned "for the family" to which the doctors and interns were also invited. A program of music and readings given by the nurses, followed by refreshments made the evening hours fly by.

"Eleven o'clock came all too soon and another night's work began, but such a lovely day will long be remembered as one of the happiest memories of my days in training."

Christmas for the student nurses at Blockley Hospital in Philadelphia must be a joyful season for Miss Ether Grimes' account of the holiday fairly radiates good cheer. She writes as follows:

"Such a hustle and bustle and stir! What is the matter with everyone! The nurses look so gay—and is this really a hospital?—everyone smiling and mysterious and so jolly? To be sure, it's Christmas time! But don't the nurses wish they were home? Don't they miss their families? Yes—but—! Why the hospital is so Christmasy, that we forget to wish for home too much, just a little wistful longing now and then. The secret is this: That never before have we been given such a wonderful chance to make Christmas for others, and after all that is a real Christmas. We begin before Christmas even planning how our wards are going to look, all trimmed up in red and green and tinsel, because the hospital always lets us have those things, not to mention the fact that many interested outsiders give us things. Our own nurses' home and all the hospital wards are literally transformed and we feel as elegant and Christmasy as the display windows down on Market Street. Christmas night we go to bed knowing that Santa Claus knows just what each one of the youngsters wants, that the Christmas trees and the evergreens and the tinsels are making our patients forget for a while and helping them remember Christmas.

"About 4:30 a.m., the night nurses begin going around on tip-toe and look—well—kind of excited and expectant, and some of the patients, who just can't seem to sleep, wonder what is going to happen. Then is the time when the nurses feel a touch of homesickness and want someone from home. For the day nurses have risen about 4:30 and by 5 a.m. are walking through the hospital corridors, singing Christmas carols. There is a hushed silence everywhere as the music draws nearer and then gradually grows fainter. The nurses feel the sacredness of Christmas in those few minutes. Then another quiet time —daylight—breakfast—'Merry Christmas, nurse.'

Breakfast by Candlelight

"When the carolling is over, we have Christmas service in the little chapel. Then we all go to the dining room, but instead of entering as usual, we find the doors closed —this means another surprise. The doors are not opened until every nurse has assembled, faculty, graduates and students. The doors then open and we find fifty candle lighted tables, in the center of each slim blossoms of narcissi, the blossoms being the Christmas greetings to the students from the head nurses. We still feel the solemnity of the day, as we sing together a strong old Christmas carol. It is Christmas morning and we remember it is a holiday, so take time to enjoy the breakfast half hour, which is such an inspirational beginning for the day. Our dietitians also remember it is Christmas, and it is their efforts that make the Christmas breakfast a real Christmas feast. Best of all is the Christmas message which each one of us finds ready for us on the table. This special Christmas breakfast is one that we never forget.

"Then Christmas day begins. We go on the wards and feel as if we are in Toyland. For Santa has been there overnight, families have not forgotten it is Christmas, and if there are no families unknown friends play Santa Claus. Everyone is remembered. Of course there is work to be done, but it doesn't seem like work there is so much gaiety and friendliness mixed in. We all enjoy sending to the diet kitchen for our share of celery and cranberry to make the Christmas dinners look so appetizing.

"The morning goes too swiftly and we are again together in the dining room and almost feel that we are home. Such a dinner and we have a whole hour to enjoy it in! Of course we all have extra time off, but those of us who cannot go home, would almost rather not go off. It is such fun to play with toys, admire dolls, and talk about 'Christmas the first few years after Jim and I were married and the children were still youngsters.'

"Christmas day is over but not the Christmas spirit. We still have our party to which to look forward. This comes about the middle of Christmas week, and then is the time when the nurses and doctors play together and celebrate the Christmas holidays. The hospital is the host for the party and we are the guests. No time or trouble is spared in giving us a good time. The evening passes almost too quickly, as we mingle together, get acquainted or listen to Christmas music, sung by some of the nurses and doctors. We have a gorgeous Christmas tree, just glistening with tinsel and shiny decorations. Before we realize it, Santa arrives, and in his heavy pack is a remembrance for everyone there. Refreshments and dancing give an interesting and appropriate finish to this festivity.

"A week goes by—two weeks—Christmas time is a thing of the past, and then we begin to think of really writing home, thereby living over again our most wonderful Christmas—the Christmas that only Blockley can give us."

Miss Bess Everett, student nurse at the Chicago Presbyterian Hospital, writes of how she and her sister nurses found it is "more blessed to give than to receive."

"It was to be our first Christmas away from home and its contemplation was not a cheerful one. And yet, about two days beforehand we began to hear tales of other Christmases and to see signs of unusual preparation. The first indication was the arrival of a big Christmas tree on the morning of the twenty-third, and as it lay propped against the wall out in the corridor of the home, we promptly began to manufacture ideas of decorations and many of us sat up a wee bit later that evening stringing cranberries and popcorn—but the real draping and hanging of tinsel was for a later time.

"Right after lunch on the twenty-fourth, our house mother set out in the main corridor some fifteen or twenty market baskets filled with the makings of as many Christmas dinners, which she and several of the nurses who were off duty had prepared that morning. The food had been purchased from a fund collected from the student body and, if I remember correctly, there had been a 'stunt show' a few weeks before which had swelled the fund somewhat. To each basket was pinned a name and address of some 'deserving' family on the West Side which had been obtained through our hospital social service department. It then became the 'Brownie's' as we colloquially call our brown-garbed probationers, privilege to distribute these baskets.

"By Christmas time, most of the new nurses had learned their way about the city, and very specific instructions as to cars and transfers were appended to each address. But even so it was somewhat of an adventure for us to actually get inside the homes in the tenement district. The recipients were most grateful and I remember how proudly one Bohemian mother took me aside to show me a new flanelette red petticoat she had managed to purchase and make for her little Maria. Oh, they hardly let us go, they were so anxious to tell us of Christmases in the old country and how they were managing to almost make ends meet over here. Perhaps there was a tear or two but it all added to the poignancy of the season.

"Then we found ourselves near Hull House and so we snatched a little time to go through it and the Mary Crane Nursery to see their holiday preparations. How we all compared notes when we got home and were draping the fluffy, snowy popcorn ropes and brilliant cranberry garlands and the cherished tinsel of other years, from bough to bought of our tall spruce standing majestically in the big class room. The tree had been wired with many tiny electric lights and way up at the tip top was a 'Star of Bethlehem.' The tree was to grace the party, which is given yearly by the student nurses for the children in the neighborhood of the hospital, and those known to the social service department.

"We were so excited over the adventures of the afternoon and the prospects of the coming party that we scarcely ate our dinner. About 7:15 our guests began to arrive, fifty or sixty of them, and here and there a bright eyed, anxious mother and a newly shaven, decidedly embarrassed head of a household. The tree was all lighted up and the rest of the lights in the room shaded with red and green crepe paper. Among the nurses we can always find a few who have taught school, kindergarten and playground, and they are the usual directors of the evening's games. We nurses, even some of the supervisors, joined in with the youngsters and played 'Drop the Handkerchief' and 'Hide the Thimble,' while in another corner some one told fairy stories and over at the piano quite

*HOLIDAY SCHEDULE FOR NURSES**

Open House from Christmas Day to New Year's Day, inclusive. Hostesses appointed from the various classes to receive each afternoon and to preside at the tea table.

Christmas Eve: Christmas tree, Santa Claus, inexpensive mirth-provoking gifts for everyone and simple refreshments such as pop corn, candy, apples, nuts.

Christmas Morning: 4 a.m., Christmas carols in the hospital; 6 a.m., short Christmas service in the Nurses' Hall, which may be conducted by some visiting minister.

Christmas Noon: Christmas dinner with appropriate decorations, favors, and toasts.

Christmas Afternoon: A country hike for the nurses who have no friends in the city and do not care to intrude on their more formal acquaintances.

Christmas Evening: A homey get-together around the fireplace with someone to read the Christmas stories and myths; music and simple refreshments.

For the remainder of the week the various classes may be made responsible for one evening's entertainment, such as a moonlight tally-ho ride in a sight-seeing bus. This is usually not too expensive and is very refreshing and enjoyable. Or a second evening may be given over to a movie or theater party, according to the finances of the group. A third evening may be some home entertainment, such as card party, dancing, or minstrel show.

New Year's Eve: The last night of the holiday week is carnival night. Carnival night with everything that goes with it. Friends are invited in, music, dancing, etc.

This suggested program leaves three free nights for the students to make any outside engagements.

*This Christmas program for the student nurse is suggested by the nurses from the City Hospital in Cleveland, Ohio.

a group entertained itself singing everything from Christmas songs to the latest jazz.

Before we knew it in came Santa Claus (some one had commandeered the fattest jolliest intern from the hospital, and he surely did play his part well), and distributed to the kiddies little red net stockings that he took from the tree. Each boy and girl made his bow to Saint Nick and thanked him for the stocking. If he or she could be persuaded to sing a song or recite, we on the side lines applauded heartily and the fond mamma beamed on her blossoming offspring. The usual things were in the stockings—candy, nuts, fruit and a 'prize.' Then in came a tea cart, with loads of ice cream and cookies for every one. Ten o'clock arrived all too soon and we bid our sticky fingered guests goodnight.

Carol Through Corridors

"Such was our Christmas eve, and while we were having our good times, the patients over in the hospital across the way were being entertained in the fern- and holly-decked chapel on the fifth floor. For them was a more sedate Christmas program of music, stories, monologues, and on occasion we have had even a clever cartoonist among the patients who themselves help to entertain in conjunction with the 'platform talented' nurses and a few kind outside friends of the hospital who came to us often to while away for the shut-ins a weary hour.

"Five-thirty Christmas morning dawned, or rather it was not yet daylight as we all assembled on the first floor of the home, spick and span in the cleanest of uniforms, and proceeded over to the hospital, where we all finally got to the top floor, and following our leader and the violinist we marched two by two down the hospital corridors from floor to floor, past the wards, past the patients we knew and smiled an answer to their Merry Christmas —past opened doors, past the children's rooms, the interns' quarters, the half deserted offices, on down past the servants' quarters, everywhere singing Christmas carols. It was truly thrilling and we just couldn't decide whether we wanted to cry at the gripping about our hearts as even the sickest folks smiled and seemed to rest more easily, or to laugh aloud at Johnny as he jumped up and down in his crib frantically waving a new toy he had found next to his pillow.

"The morning's duty hours went like lightning and everybody was happy. Dinner, and such a meal! Everything from 'soup to nuts.' Those who weren't on duty during the afternoon hiked out to the park to skate or went to the theater or wrote home—I guess we all wrote home some time that day. And in the evening we wound up the two days' festivities with a party for ourselves where we danced and could bring our 'grown up' guests.

"Truly I shall never forget my first Christmas in training and am really looking forward to a repetition of all my training school Christmases again this year."

The class of 1922 joined efforts at the Illinois Training School in giving the following account of their jolly Christmas of a year ago:

Extra! Extra! Extra!

"Of all the happy memories, those clustering about Christmas, no matter where spent, are always closest to our hearts. Although it is the merriest, jolliest season of all the year, to those away from the home fireside for the first time, perhaps, it may easily become a sad, lonely experience. But to the student of the Illinois Training School, the memory of our last Christmas spent here easily puts to flight the mere possibility of such an unhappy occurrence.

"First are the 'handbills.' Everybody likes a morning edition and here, throughout the holiday season, we have miniature newspapers edited by various groups, from which no one from faculty to probationer is excluded. These papers contain bits of news and gossip, a favorite or original poem, plenty of jokes, and amusing cartoons. Each number features some particular department of our training: the nursery, the operating rooms, the class room, etc. Every morning ambitious newsies, either go through the halls with their "extra" or take their stand at the door and sell them. Needless to say, these school papers find ready sale and contribute something to the atmosphere of cheerfulness.

"One of the wonderfully impressive customs of the Illinois Training School is the singing of Christmas carols early in the morning, while it is yet dark, by a group of students who pass through the corridors of the home and hospital, candles lighting their way.

"I sure thought it was the angels singin'," said one of the patients, awakened by carols echoing and re-echoing through the spacious halls.

"The children's wards, always interesting places, were never more so than at Christmas time. All spare moments were given to preparations behind closed doors, where stockings were filled, toys sorted and arrangements made for the big tree, not to mention Santa's costume. All this added to the air of mystery and expectancy in which the children lived during this wonderful week, producing many whispered confidences and a studied, almost angelic behavior, for they remembered the old admonition that 'if you aren't good, Santa won't bring you anything.' Bringing cheer to those in the hospital whose hearts might otherwise be sad is by no means the smallest factor contributing to the Christmas joy of the nurses.

"The Christmas party at the nurses' home was the biggest event of the week. Everyone was already prepared to enjoy this festivity because of the festal spirit which had found its way into all parts of the home. The hall, beautifully decorated with Christmas greens, the soft glow of dimmed lights, the holly sprigs above the fireplace, the always welcome postman with his heavy load of packages—who can forget these impressions? The party opened with a program consisting of several numbers, the originality of which could hardly be disputed. These amused the audience while awaiting the arrival of Santa Claus, due on the next reindeer express. With his appearance, the party became as jolly as one could wish. But it almost ended disastrously when shortly after his arrival, Santa Claus suddenly developed a severe pain which we, as expert diagnosticians, immediately pronounced acute appendicitis. Emergency measures were at once taken; the platform quickly transformed into an operating room. Santa was placed upon the table; ether administered with a soup ladle in lieu of a mask; the incision made; and such an anatomical disturbance was found! Numbers and numbers of foreign bodies were discovered and removed by an able surgeon. On examination these proved to be gifts for everyone. The operation was a success. Santa Claus lived. Then followed ation was a success. Santa Claus lived. Then followed the distribution of gifts from the tree, refreshments, informal dancing and games. The evening passed only too quickly.

"Christmas itself, with all its gaiety and good times, was soon a thing of the past; but its memories remain, and, as said before, are very happy ones."

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Director, Dietary Department, Mt. Sinai Hospital, New York.

DIETITIAN'S PART IN SPREADING CHRISTMAS CHEER

TWO years ago several dietitians were asked to tell some of the methods they employed at Christmas time to bring cheer to patients, nurses, employees and others, forced to be away from home at this season which is so full of thoughts and memories of home and family. The request met with such an enthusiastic response and so many dietitians expressed gratitude for the suggestions contributed that the request was repeated this year. The majority of dietitians, it seems, consider Christmas a challenge not only to their best efforts and greatest skill in preparing a holiday feast but to their spirit of thoughtfulness as well. Not one letter received made any reference to the additional work or the numerous difficulties which a Christmas dinner implies. On the contrary, there were expressions from many indicating solicitude for the happiness of the patients and of their co-workers for whose Christmas dinners they were responsible. On the whole it would seem that the greatest joy of all hospital workers is found in doing for others, and, of course, no Christmas is complete without a dinner that savors in some way of a feast. Can you not feel the expectancy at Peter Bent Brigham as described by Miss Octavia Hall:

"Christmas day is always a day one wishes to be at home. In a hospital, everyone is away from home and so it becomes one of the greatest pleasures of Christmas to make them forget by bringing as much happiness and good cheer to them as possible.

"Of course the patients are the first and foremost consideration. The nurses always feel the Christmas spirit to such an extent that they themselves plan attractive little favors and decorations for their patients' trays. The hospital buys decorations such as wreaths and trees. There is a lovely, gaily trimmed Christmas tree in each ward and many pretty wreaths at the windows and doors. Santa Claus comes around and wishes a merry Christmas to all and gives each patient some little present.

"Even after the visit of dear old Santa Claus, the patients still have an expectant look. Nurses hurry around more than usual and about twelve o'clock the most attractive trays begin to appear at the bedside of each patient. Some wards have pretty crepe paper baskets of nuts and raisins, and small red stockings full of Christmas candies appear on the trays. The patients have the following menu served to them: Tomato bisque, celery, turkey, dressing, cranberry sauce, giblet gravy, mashed potato, cauliflower, tutti fruitti ice cream, nuts and raisins.

"The nephritic and diabetic patients, of course, have weighed diets. In the diet kitchen has been written for all of the patients little place cards with a verse on each about the patient himself. This helps to take his mind off the fact that his neighbor is eating turkey or candy while he has none. But the diet kitchen has made everything as much like the regular house diet as possible and has introduced a tomato aspic salad in as many diets as will allow it. This helps to carry out the Christmas color.

"In one ward there are so many patients able to be out of bed that a table is set in the middle of the ward. Nurses have brought decorations of crepe paper and have prepared an extremely attractive table for the patients to sit down to just as they would do at home.

"The nurses' dining room is decorated with holly wreaths and red bows at every window. Ropes of mountain laurel are festooned across the room. The centerpiece on each table is a flat holly wreath with little pine trees in the center. A few of the doctors have brought some pine trees, and little twigs are cut from these and

*WHY KNOW PER CAPITA COSTS?**

In the past two years the writer has asked dozens of dietitians what their per capita cost is and not one in ten can tell. Some of these women have the reputation of being excellent dietitians though they apparently know nothing of the cost of running their department.

Dietitians in a large percentage of our hospitals are executives and usually they are members of the instructional staff. Do good executives in business ignore their cost accounts? Instructors in other phases of home economics know the exact cost of the course they are giving and usually the cost of each class group. Is the dietitian's work so different that it has no need of this knowledge?

Granted that she never buys anything she does not need and that she is too busy to do bookkeeping, can the dietitian give the best service to her institution by ignoring this item and giving her whole attention to other things? Or can she serve best by knowing the cost and letting it influence the management of her department?—EDITOR.

*This is the second of a series of queries which will be a regular feature of the Department of Dietetics and Institutional Food Service for a number of months, depending on the interest which the questions arouse. Discussion is invited, with a view to summarizing and publishing in later issues of the magazine the opinions of dietitians, hospital superintendents and others.

put together so as to make miniature Christmas trees about eight inches high. These little trees are trimmed with bright tinsel.

"The doctors' dining room is trimmed in the same manner save for the fact that the very large round table is set for everyone and a Christmas tree with lighted candles burns cheerfully in the middle of the table when they come in. A bright fire burns also in the fireplace, a spot that had been considered a mere cavity in the wall and in which the tea wagon was wont to find shelter. The menu is: Oysters on half shell, celery, olives, radishes, turkey, dressing, gravy, cranberry sauce, candied sweet potatoes, creamed cauliflower, waldorf salad in red apple cups, wafers, tutti fruitti ice cream, cake, demi-tasse, raisins, nuts, fruit and peppermint candy. Two turkeys, done to a golden brown, are brought in and two of the doctors carve them. 'May I ask you to pass the sweet potatoes, please?' is heard, and it seems like a big family dinner. When the coffee is served, the cigarettes lighted, the chairs pushed away from the table, and a good story started, it really begins to seem as if it were not so hard to be away from home on Christmas day after all."

At Massachusetts General Hospital also every patient able to sit up for even a short time had a place at the gaily decorated table. Miss Jessie Campbell tells us that this dinner is made more complete because a Christmas cake is provided by the head nurses. Special preparation is also made for the diabetics. They are given roast turkey, weighed to conform with their prescription; if possible the same vegetables are given to them that are served the others; salad of fresh tomato, lettuce, celery, and a dessert of agar jelly molded in fancy shape gives a festive appearance to the service. When permissible, forty per cent cream is weighed, whipped and served with the jelly. Cellu bran is also served (see recipes).

Napkins as Menu Cards

At Alameda County Hospital, California, native red berries are used on the trays. In the wards the menu is printed upon the napkin, and for private patients artistic cards are used to carry the menu. Fancy boxes with simple candies suitable for sick people are also on the tray. Miss Kerr says her menus are always made with a thought for everyone. There is fruit juice gelatin for the liquids and Spanish cream for the soft diets. Molded chicken consommé is a simple and delightful variation. Carrot pudding is substituted for plum pudding, made with butter instead of suet.

Miss Buckles, also, serves carrot pudding for which she has sent a recipe. Here, too, is her candle salad. A slice of pineapple is used for the base and one-third or one-half a banana placed upright in the center to represent a candle, topped off with a cherry or otherwise garnished.

Don't you like Miss Rinehart's, Pasadena, Cal., idea of serving a plate of fruit on Christmas morning? The plate contains a bright red apple, orange, raisins and nuts. It adds to the festive appearance of the room, and if the patient cannot eat it himself, he can offer it to his callers.

Miss Laura Bowles writes us from Sacramento that the Santa described by Miss Deaver in this department in 1919 afforded much pleasure to the patients and nurses as he stood on the tray with a real Christmas dinner. The graduate nurses in the hospital made the "Santas" and thereby shared in the fun.

Another example of helpfulness is shown at the Methodist Hospital in Omaha. The trays last year each had a hand painted card with the patient's name on it; these were painted by a pupil nurse anxious to earn a little extra money. There were also individual candle sticks, one and a half inches high, holding a little red candle. These were placed on the tray and lighted just before it was taken to the patient. Wouldn't such a tray bring joy to any patient! However, Miss Ehler says the real "hit" was made by scalloped celery being served in individual pyrex dishes in which was placed a miniature Christmas tree. These trees were made from green paper cut and wrapped on a toothpick. Colored skewers could be used with similar effect.

In Louisville City Hospital, as in all city institutions, turkey or chicken is a rare treat to patients and almost equally rare for nurses, doctors, and employees. To quote Miss Howington, "the good news spreads through the city that the hospital will again put the little pot in the big one for Christmas and we are usually crowded for that day." Decorations and carol singing are supplemented by the beautiful old custom of burning a candle in the windows. The children's ward has a tree and Santa Claus provided by the social service department. The matron and dietitian make colored stockings and fill them with candy, fruit and a small toy; these are distributed Christmas morning by Dr. Tuley. Now comes the idea that I am sure is distinctly a Louisville City Hospital idea—A layette is provided for the first baby born on Christmas day on both the white and the colored obstetrical wards.

Party for Employees

Another unusual feature is the custom at Youngstown City Hospital, as told by Miss Winans. "The best Christmas treat for the employees with which I have helped was an absolute surprise to them. All the employees and their families living on the grounds were invited to the nurses' home from six to seven on Christmas Eve. They enjoyed the nurses' tree and decorations; a short program of songs and readings was followed by greetings from the superintendent. A treat which was given by the ladies' board was distributed, and they went happily away to their own celebration. When the nurses came off duty at seven they were all gone.

Since the training school at Mt. Sinai in New York is non-sectarian, the nurses have a very real holiday celebration. Money is contributed by the board of directors and interested friends which provides two pounds of good candy for each nurse in training and also provides a fund for purchasing books for their library and records for their victrola. There is always a tree and other decorations in the nurses' home. During the week a party is given at which is served homemade cake furnished by the supervisors.

A menu (No. 1) for an 150 bed hospital was sent us by Miss Joseph with the comment that she always considered the help and planned a menu on which much of the work could be done in advance so as not to interfere with half-days. The plum pudding was made just after Thanksgiving and the mince pie the day previous, and reheated. Trays are decorated and carols sung. A red ribbon tied around the glasses gave a bright touch to the tray.

Miss Proudfit is planning a health play for this year in which the nurses are to act. It is a fairy story dramatized for the children who are able to be taken to the nurses' recreation hall. For the older people, doctors, and nurses there will be enacted a series of scenes from the life of a nurse—and they will not all be solemn scenes either. Gaily trimmed bags of fruit will be distributed in the morning. The kiddies of this hospital are pleased

with a bright new five-cent piece placed in the toe of the stocking filled with candy. Carol singing is in the afternoon, so as not to interfere with hospital routine.

(1)

MENU (PATIENTS)

Clear Broth with Noodles

Turkey Dressing

Celery Olives

Molded Cranberry Jelly

Asparagus Mashed Potatoes

Ice Cream Pound Cake Christmas Cookies

Mints Coffee

MENU (NURSES)

Noodle Soup

Turkey Oyster Dressing

Cranberries Olives Celery

Mashed Potatoes Baked Squash

Plum Pudding Hard Sauce

Raisins Salted Peanuts Candy

Coffee

MENU (HELP)

Noodle Soup

Turkey Cranberry Jelly Dressing

Mashed Potatoes Squash

Mince Pie Coffee

Raisins Peanuts Candy

(2)

LOUISVILLE CITY HOSPITAL

(Doctors, Nurses and Employees)

Breakfast—Grapefruit, eggs, toast, coffee, cereal, jam.

Dinner—Roast turkey, dressing, cranberry sauce, mashed potatoes, celery, buttered peas, coffee, plum pudding and sherry sauce.

Supper—Hot coffee, bags containing fruit, candy, cakes and nuts furnished to all.

Regular Diet for Patients

Breakfast—Oranges, cereal, coffee, toast, hash.

Dinner—Turkey, dressing, mashed potatoes, celery, cranberries, milk, chocolate pudding and sauce.

Supper—Bags same as nurses, coffee and milk.

Modified Diet for Patients

Breakfast—Orange, coffee, cereal, toast.

Dinner—Chicken soup, mashed potatoes, celery, milk, toast, chocolate pudding.

The following recipes include those referred to above and a few others:

AGAR JELLY

Agar jellies are made by adding one tablespoon of powdered agar to a pint of boiling water. When the agar is dissolved, pink vegetable coloring is added with saccharine and a synthetic fruit flavor to taste

CELLU BRAN COOKIES

Cellu flour 25 gms., dry washed bran 60 gms., India gum 10 gms. Salt to taste. Cinnamon 1 teaspoonful, mineral oil, 6 tablespoonfuls, saccharine 1 grain, hot water 100 cc.

Mix dry ingredients thoroughly. Add oil flavor and hot water in which saccharine has been dissolved. Shape in very thin cookies and bake in hot oven until crisp and brown.

CARROT PUDDING (20 SERVINGS)

1½ c. grated carrots, 1 c. raisins, 1½ c. milk, 2 c. flour, 1 ts. cinnamon, ½ ts. cloves, ½ ts. allspice, 1 ts. soda, ½ ts. salt, 1 c. suet, 1 c. sugar, 1 ts. baking powder. Steam three hours. Serve with sauce.

CHERRY SPONGE (25 SERVINGS)

One cup each sugar and water. Add 1 qt. pitted cherries, simmer until soft. Press through colander. One-half box gelatin dissolved in ½ pt. hot water in which pits have been stewed, add to fruit. When jelly-like, whip to froth then add beaten whites of 2 eggs. Mold. Decorate with cherries and whipped cream.

CRANBERRY ICE (100 SERVINGS)

Eight qts. cranberries, 4 qts. water, 4 qts. sugar, juice of 12 lemons (1½ c.). Cook cranberries in water. Force through a sieve, add 1-2 qts. water. Add sugar and lemon juice. Freeze to a mush.

PEPPERMINT ICE CREAM

One lb. peppermint stick candy, 2 qts. cream. Crush candy. Heat cream in double boiler, pour cream over candy, stir well, cool. Freeze.

ORANGE PUDDING (35-40 SERVINGS)

Thirty-four orange juice, 4 lemon juice, 4 c. sugar; mix. Add 16 egg yolks beaten and ¼ cup cornstarch. Cook in double boiler until it begins to thicken. Add 3 tb. gelatin soaked in ½ cup cold water. Dissolve in ½ cup boiling water. When mixture thickens, add 16 egg whites beaten stiff.

CREAM CHEESE

Mix cream cheese with chopped pecans. Mold two in brick. Cut in ½ in. slices. Serve a heart of beet on each slice.

ENDIVE AND TOMATO

Separate endive like celery stalks; lay in ice water half an hour and wipe dry. Peel some small tomatoes and cut into sections like oranges; put the endive on a cold dish with a little lettuce beneath it and arrange the tomatoes at the sides. Cover with French dressing.

BIRD'S NEST SALAD

Cut fine large tomatoes in halves and remove the inside. Make cottage cheese into small balls the size of marbles, and flavor with a little sage, rubbed through a sieve, and salt. Put three balls into each tomato half and arrange the tomato on crisp white lettuce leaves, or surround with the delicate leaves of watercress. Serve mayonnaise with this salad.

WHITE GRAPE SALAD

Cut white grapes in halves and remove seeds. Chop olives, not too fine. Make a gelatin solution in which a little lemon juice and sugar has been dissolved, not enough to flavor strongly. Add grapes and olives to solution. When it is solid cut in cubes and serve with mayonnaise.

CURRANT JELLY SAUCE

One cup currant jelly, separated with a fork but not beaten, 1 scant cup of finely chopped mint leaves, shavings from rind of two oranges, or grated rind. Mix carefully and serve with lamb or chicken.

SANDWICHES

One-half cup candied cherries, cut fine and flavored with two tablespoons of orange juice. Spread on crackers. This makes a very pretty and palatable sandwich.

Dates cooked, chopped and flavored with lemon juice make a delicious sandwich filling. Chopped peanuts are a desirable addition for some occasions.

RETURNS TO A. M. A. COUNCIL

The American Medical Association has recalled Mr. Homer S. Sanger to his former position with the council of medical education and hospitals. His work, in addition to hospital surveys and statistics, will be to assist in the assembling and publishing of information regarding dispensaries and clinics. Mr. Sanger will be remembered for his former work as superintendent of the Central Free Dispensary at Rush Medical College, Chicago.

FAVORABLE REPORTS FROM MIDDLE WEST

The editor of this department had the pleasure of visiting several hospitals in the Middle West during the past two months and found that these hospitals, along with the fifty or more which we had the privilege of visiting last summer, attach great importance to the dietary department. In every instance the medical men, as well as the superintendent, stated that they would never again try to run a hospital without a good dietitian. Is there any significance in the fact that six of the nine hospitals visited had women superintendents, including two Catholic hospitals?

In Council Bluffs, the Mercy Hospital recently engaged Elizabeth Powers to take charge of their diet kitchen and to teach the nurses dietetics. A room which at first seemed to offer a few possibilities, has been fitted up for a diet kitchen and through Miss Powers' ingenuity and a carpenter's skill, it has acquired conveniences, and many unique pieces of equipment which were originally made for much different purposes.

The medical men speak highly of the work of the department and say the patients are pleased. Can it be true? We recommend visitors in Council Bluffs to visit this hospital; they will find Sister Benedicta charming and cordial.

St. Joseph's Hospital in Omaha is another Catholic hospital having a dietitian, Miss Mabel Brown, who has been in this position for about three years. Here, too, a diet kitchen was equipped after the dietitian was secured, and Miss Brown has a very attractive, well lighted workshop. The doctors and dietitian are doing splendid teamwork and thereby getting very gratifying results.

At the Methodist Hospital in Omaha, Miss Ehlers has charge of the entire food service, and we pronounce it a splendid food service with emphasis on both the food and the service. Miss Ehlers has promised to tell us of her work so we shall not attempt it. A genuine family spirit prevails. This hospital sent the president of the board, the superintendent and the dietitian to the meeting of The American Hospital Association at West Baden.

At Peoria we found a newly equipped kitchen and diet room but no dietitian. This lack was due to the difficulty in finding dietitians at present, but Miss Serbray had succeeded in finding a prospective dietitian who is probably with her now.

The Home Economics Departments at Bradley Polytechnic Institute and Proctor Hospital are planning a course of training for dietitians next year which promises much.

Dietitians in New Locations

It is to be regretted that so many dietitians are having to give up work on account of ill health. Our last issue contained a report of several such instances and we continue to hear of others. It is gratifying, however, to know that a number have again taken up their duties.

Miss May Foley is back at Mayo Brothers Clinic, Rochester, Minn.; Miss Maud Perry has returned to Montreal General Hospital, though she has not quite regained her normal health; and Miss Martha Kimball has recovered sufficiently from a long illness to continue her work at Minneapolis General Hospital.

Other changes which have been made by dietitians are as follows: Edna Becker gave up her position at the University of Chicago to become Miss Little's assistant at Madison, Wis.; Miss Mary Merle Buckles is at the Memorial Hospital, Richmond, Va.; Esther Ackerson Fischer is no longer at the Chicago Beach Hotel, Chicago; Dorothy Case has gone from Youngstown Hospital, Youngstown, Ohio, to a position in Detroit; Margaret Royal has accepted a position in the Children's Hospital, Detroit; Margaret Drew is with the Northern Pacific Beneficial Association in St. Paul (she was dietitian at the Northern Pacific Hospital at Brainerd, Minn.); Candace Easton is at her home in Monroeville, Ohio, since resigning from the U. S. P. H. S.; Anna Gehman is again at Griffin Hospital, Derby, Conn., after having been in other positions for two years; Zoe Harris has been chosen chief dietitian at the Missouri Baptist Sanitarium, St. Louis, Mo.; Josephine Holman is at Lawrence Memorial Hospital, New London, Conn.; Miss Lillian Karus, formerly at U. S. P. H. S. Hospital No. 30, Chicago, has been appointed chief dietitian of the Edward Hines, Jr. Hospital, Maywood, Ill.; Dorothy Olvey has accepted a position at the City and County Hospital, St. Paul, Minn.

We are concerned about the secretaries of the various city associations. We hope nothing serious has happened but there must be some reason for the lack of reported meetings. Not one report of local dietitians' association meetings has reached us. Surely there have been some October and November meetings.—EDITOR.

OHIO PLAN TAKES HOSPITAL FACILITIES TO THE CRIPPLED CHILD

In their efforts and achievements in taking hospital facilities to the crippled child, instead of bringing the crippled child to a central hospital, the Rotarians of the tenth district, organized as the Ohio Society for Crippled Children, are accomplishing a practice which they believe to be unique.

The Ohio plan, as fostered by members of the Rotary club in that district, reverse the old order of things in which crippled children of the state are brought to a single institution for remedial treatment and establishes in the state different districts, each equipped for handling the crippled child. The Ohio program when complete will provide ten or twelve working centers with total hospital facilities of from 500 to 1,000 beds. Nine are now in operation.

Rotarians in Ohio have set down for themselves the following goals in establishing centers for the care of the crippled child:

1. Hospital facilities of twenty or more beds in a thoroughly organized hospital, having a competent nursing force and proper equipment for all classes of work for crippled and deformed children.
2. The establishment of a weekly clinic for new cases and also old cases where the patient can return to have casts and braces adjusted, x-rays, and examinations.
3. An attending orthopedic surgeon with a consultant.
4. A survey of the entire district with complete records of all cases.
5. A system of follow-up work so that cases will have correct home treatment.
6. A school for the education of crippled children in the district and bedside teaching for children in hospitals.
7. Classes for slightly deformed children where corrective treatment may be given.

The Rotary Club in the tenth district was sponsor for the legislation which makes it possible for crippled children to be treated at state expense. Ohio is said to have 12,000 crippled children. One thousand of these have already received treatment at the Gates Hospital in Elyria.

The public safety is the supreme law.—Bacon.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

HOW TO SERVE FOOD "PIPING HOT" TO THE PATIENT

THE tastiness of cooked food and, in some instances, its nutritional value, depends to a marked degree upon the temperature at which it is served. To serve foods "piping hot" has always been a problem. Even in the home, where the task largely resolves itself into the proper timing of cooking operations, it has been considered the measure of a good cook to be able to serve all dishes at the proper temperature.

The ideal and, likewise, the most simple method of insuring hot food service is direct from the range to the individual. This was the original order in public eating places, and even today is followed on "short orders." As conditions became more complex, as eating places became larger and meals were served for a longer period of time, a different kitchen routine was established. This is particularly true in those restaurants and eating places where established menus are served.

To meet these new conditions, the modern steam table was designed, in which cooked food is kept at a constant temperature by means of a water jacket or water pan, which, in turn, is heated by gas or steam. This method has been the accepted installation in restaurants, cafés, hotels and, until of late, the majority of hospitals. There is no question but that the steam table of today serves the purpose of keeping the food hot. It cannot, however, be said that steam tables maintain the palatability of food or that food does not suffer to some degree by being kept at a semi-cooking temperature.

Figure 1.

Figure 2.

Figure 3.

With the development of the modern hospital, food service has become a far more complicated problem, until it is conceded that the steam table as used in the general kitchen is not an aid, but rather a detriment, to efficient food service. This statement naturally does not apply to every institution. To those hospitals which are able to serve all patients direct from the central kitchen, where possibly the food service devolves upon a limited number, thus lengthening the time of the meal, the steam table is still an essential. In the larger modern institutions, however, the use of a steam table, according to present kitchen routine, means but an additional handling of the food without added benefit.

This change in hospital food service is due to several factors. The increase in size of institutions made it increasingly difficult to serve all from one central kitchen. The change in hospital design was another factor. The pavilion, cottage and wing type of construction demanded different methods in food service. Ward kitchens or at least serving rooms were installed. The increase in the number of private rooms called for a further modification in methods of serving food, while the advance in dietetics with the resultant special diets added another complication.

The modern routine of food service calls for the food to be prepared in a central kitchen or kitchens, served direct from the range to various containers, and then transported to the outlying cottages, buildings, various wards or floors for service at the bedside or from special serving rooms or diet kitchens. This change brought into existence a wide range of food service containers and carriages to meet different conditions. There is a total lack of standardization in such equipment. In fact, it does not seem possible to effect approved or standardized equipment, because of the wide variety of conditions existing in various hospitals. Therefore, no attempt is made in this article to recommend any particular type of equipment, but rather to present illustrations and descriptions of various types of equipment from which the hospital executive will be able to select and adopt the type or types most nearly meeting the special requirements of his institution. The use of the illustration must not be construed as a recommendation of the product of a particular factory but as presenting an example of general design.

No attempt will be made to illustrate or describe the simpler forms of food containers or carriages, which are merely vehicles of transportation and do not attempt to provide means of retaining or furnishing heat while the

Figure 4.

food is being transported. There is a wide variety of such equipment which is undoubtedly valuable in simple installations where difficulty in keeping the food hot is not a problem.

In studying the equipment described, it is at once apparent that there are two general divisions. The first, by means of insulation, aims to retain the original heat of the food. The second class does not depend entirely upon insulation, but provides means of adding heat to the food and thus maintaining proper temperature for serving.

The simplest form of insulated food containers is the so-called vacuum bottle. These containers are made of either glass or metal with a double wall in which a vacuum has been created, this vacuum insulation successfully maintaining temperature for a considerable period. Although intended primarily for the storage or serving of liquids, certain forms of these containers are also suitable for more solid foods. Owing to the fact that the original temperature can be maintained for long periods, vacuum containers are more useful for the storage of foods than merely for transportation and service.

Figure 1 represents a common type of the vacuum bottle, the wide mouth allowing solid and semi-solid foods to be served.

Figure 2 is a vacuum carafe which is particularly suitable for room service.

Figure 3 is a vacuum pot which is made in different sizes and designs and which is highly desirable for the service of hot beverages, broths, soups, etc.

All of these containers are made in a variety of styles and finishes, and while excellent for keeping foods hot, can also be used in the storage of cold beverages and foods.

Figure 5.

It is a natural step from considering the small vacuum containers of limited capacity to study the large size containers in which the same principle is employed. In these cases a vacuum container of metal is furnished in which a number of separate utensils can be fitted, permitting the transportation of these containers a considable distance without appreciable loss of heat even after many hours. Such vacuum containers are made in various sizes, holding a number of individual containers, these being, as a rule, made of aluminum with tight fitting lids. The adaptability of such service to larger institutions with outlying cottages or pavilions is self-evident. The food can be either cooked in the small containers or served direct from the range after which the containers are stacked in the vacuum insulated holder and are then ready for carrying a very considerable distance.

A similar outfit is now being made in a large range of sizes in which the outside container is insulated by a special insulating material instead of by the vacuum walls described above. This outfit is shown in figure 4, and this illustration, while specifically showing the specially insulated container, is similar in appearance and design to the vacuum container described in the preceding paragraph. The outfit is furnished with a single large interior container, if desired, or with a number of small interior containers which may be stacked for convenient heating. In fact, almost any modification in the size of the outfit or of the interior containers can be secured in order to meet the special requirements of various institutions.

There has been recently designed a special device par-

Figure 6.

ticularly adaptable for food service in private rooms or small wards (figure 5). While relying on the exterior container for the retention of heat, provision is also made for heating special asbestos pads which add to the heat retaining qualities of the outfit. This device has been used with considerable success by a Chicago hospital where special electric cabinets have been installed as a convenient method of heating the asbestos pads. The outfit consists of a fiber exterior container. The food is placed on various shelves of the rack and then the entire set is placed in the carrying container. Specially prepared asbestos pads which have been heated fit into the removable cover, keeping the food and dishes warm, provided service is fairly prompt. This device is suitable only for limited service, as the entire outfit weighs but eight pounds, is twenty-four inches in height and twelve by fourteen inches in width and depth.

The equipment thus far described does not offer means of ready transportation. Special utility trucks or wagons must be employed. In the average hospital, however, it has been found more convenient to have food service carts mounted on wheels or casters, permitting immediate and ready transportation to other buildings, floors or the various wards.

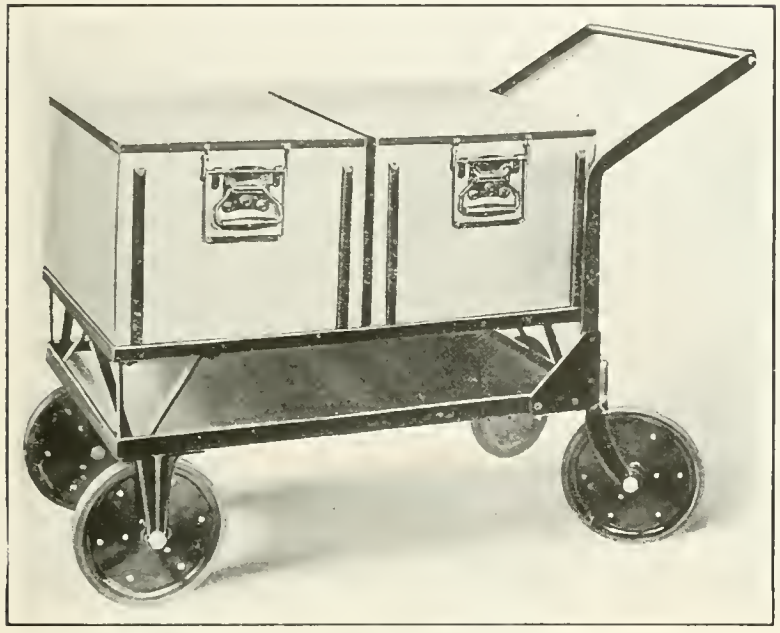


Figure 8.

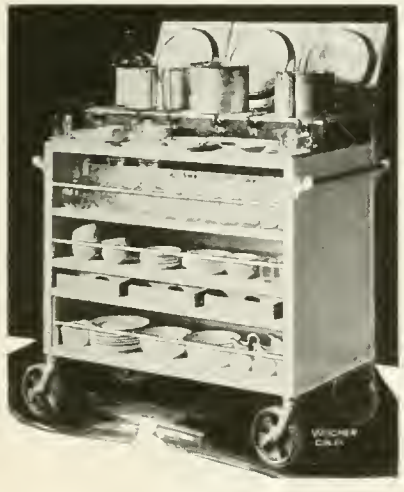


Figure 8a

There is a wide range of such food carriages with different arrangement of shelves and doors, each representing the ideas of certain hospitals.

The food carriage shown (figure 6) perhaps represents the more approved type. Sliding doors have the advantage in that they do not

Figure 7.

produce the vacuum or pressure that is frequently present in opening and closing hinged doors. The various compartments of this wagon are absolutely separate, being divided with double steel walls, lined with asbestos. The entire compartment is made with double walls on the back, sides, top and bottom, lined with asbestos, retaining heat to a large degree. Various sections are divided by uprights walls so that the tight fitting sliding doors close each separate space, preventing the other compartments from cooling. A further feature of the particular wagon shown the rubber corners which prevent injury to hospital walls. Food can be carried in this wagon in the original containers or in special aluminum containers with inset covers, such as are used in fireless cookers. It is claimed that the design of the running gear in this particular wagon has many advantages over ordinary four wheel construction, as the weight is carried to a large degree on the larger wheels.

The more direct application of insulating material has resulted in several different types of food carts which are constructed on the fireless cooker principle in which the food containers are completely and closely surrounded by specially prepared insulating material. This method permits the food to be cooked in these special containers and then placed directly in the cart, or else served from larger utensils and then transported to the ward. Service in the ward may be made direct from the container at the bedside or, if desired, in the special serving room or diet kitchen. It is customary in the fireless cooker type of food carriage to have separate units each con-

Figure 9.

taining four or six food containers. These units can be removed from the truck and sent from or returned to the kitchen by elevator or dumb waiter.

Figure 7 shows one of the smaller types of food carts, this particular cart having a capacity for a four dish meal for from 25 to 40 patients.

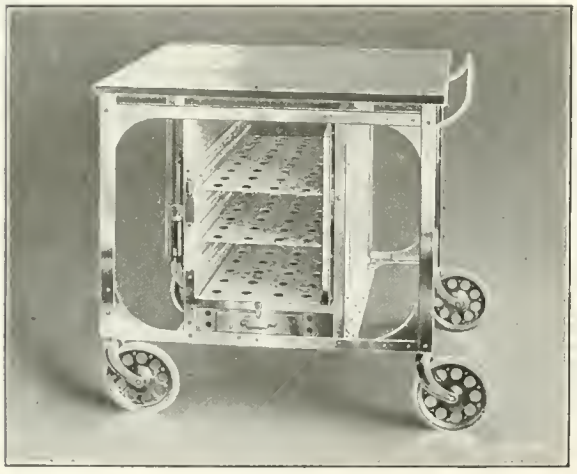


Figure 10.

Figure 8 is a larger outfit of similar design, except the insulation does not surround the food containers but is limited to the exterior walls. The illustration shows two separate units each containing food utensils. In this particular design the units are set on a removable platform so as to elevate them to more nearly table height and to provide a shelf for dishes, trays, etc.

There are many advatages in the fireless cooker type. No heating element is involved and the operation of such service requires but little attention, while the heat of the food is retained to a very high degree.

A modification of the fireless cooker idea is shown in figure 8a and provides all necessary facilities for hot food service at the bedside. The outfit includes in addition to the insulated food containers shown at the top, various shelves for carrying dishes, cutlery, glassware, etc., and provide in this way what is practically a complete unit. The insulated containers or fireless cookers contain a large aluminum receptacle in one, two receptacles in another, while the third contains three aluminum receptacles, thus providing storage for a six dish meal.

One of the simplest forms of food cart is shown in figure 9. It consists solely of the carriage of more or less regulation pattern, which is provided with four or more copper boxes provided to suit. The food is placed in these boxes in bulk and then sent to the diet kitchen where it is either served direct or reheated. This type of cart depends solely upon the containers to retain the orginal heat of the food.

When dependence is not placed upon insulation for retaining heat, it is necessary to provide heat in some other manner. This has been done in a variety of ways, all of which have their advantages and, likewise in many cases, very distinct disadvantages.

Figure 10 shows a combination food cart and serving table. The cabinet in the center is made with double walls, insulated with mineral wool. A specially prepared composition bricklet is supplied which is supposed to be an odorless heating element. The top is of polished

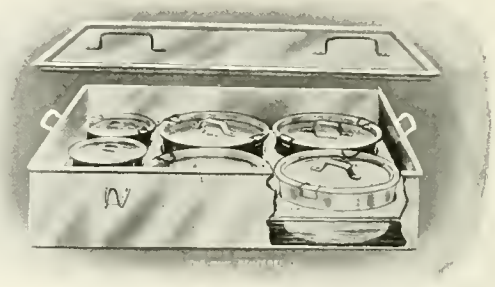


Figure 11.

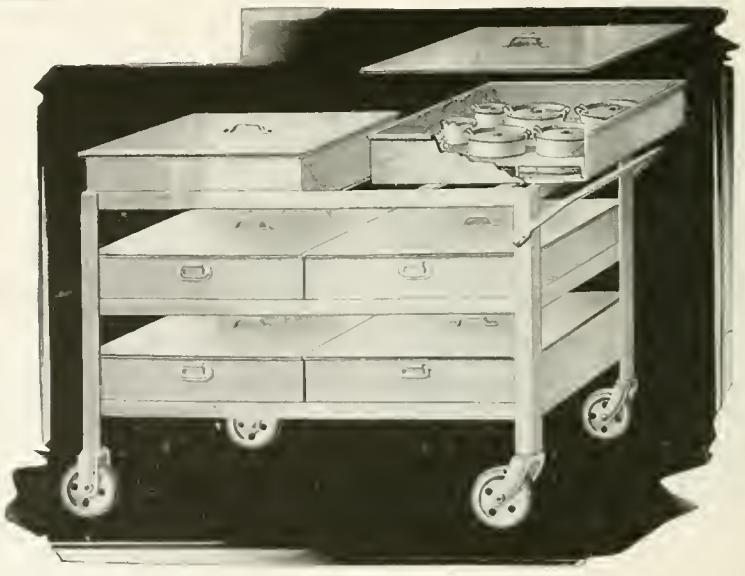


Figure 12.

mahogany and may be used for serving a meal to convalescent patients or as a bedside tray. This outfit is not designed for wholesale feeding, but is better suited for private rooms or small wards. It undoubtedly has considerable value in a limited number of institutions, particularly of the sanatorium type.

One of the common methods of maintaining heat is by means of a hot water jacket. There are a number of such food carts sold, some depending solely upon the hot water, while others provide a special heating stone, placed in or under hot water tray. An electrical connection which can be made after the cart is brought into the ward or serving kitchen is a feature of some models.

Figure 11 shows a typical food tray with aluminum insets and hot water base. These are, as a rule, made in units to insure easy handling.

In many government institutions a simple form of food cart containing such trays is employed. This is well illustrated in figure 12. It is a simple skeleton truck made to hold six food boxes, each containing aluminum containers and hot water base.

A smaller and simple design of food cart with hot water heat is shown in figure 13. The lower compartment provides storage space for dishes, trays, etc.; the upper part contains food receptacles with covers. These are kept warm by hot water, provision being made at the side for drawing off the water upon its return to the kitchen.

Figure 14 is more elaborately designed, having seven food receptacles in the rectangular container and a meat tray with a telescopic cover.

In the one end of the lower cabinet a compartment is provided for hot coffee, with an independent heater. The rest of the lower compartment is provided with shelves for dishes and trays. The outfit is designed for hot water base with further provision for soapstone blocks.

Figure 15 is a compact, convenient type of food cart with a rectangular copper container having a meat box and several aluminum receptacles. A hot water base, with provision for heating stones, is utilized for retaining the heat. This cart also provides other conveniences, including a cupboard with three shelves at the top for

Figure 13.

Figure 14.

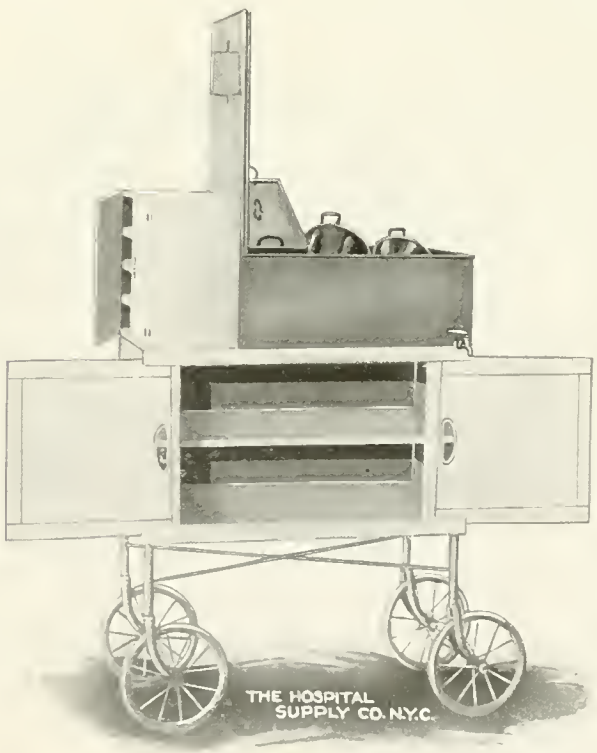


Figure 15.

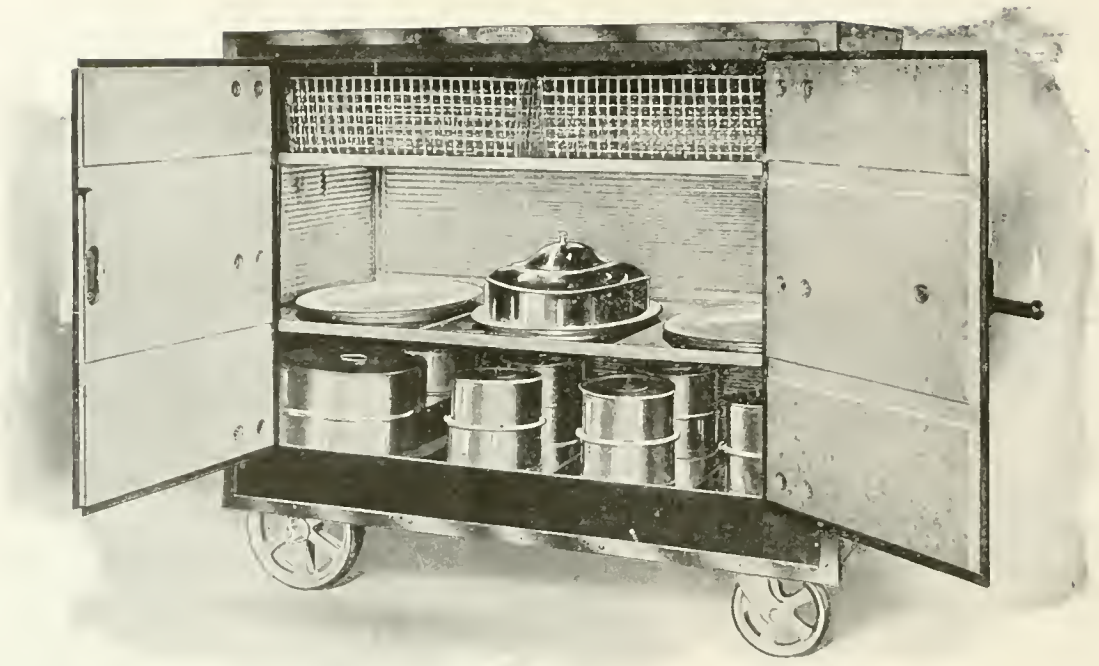


Figure 16.

holding bread and similar food, and a compartment with sliding doors below for dishes and other utensils. While this cart is primarily designed for hot water heat, it also permits of the installation of electric heating devices.

Larger institutions will be particularly interested in the complete food cart shown in figure 16. The cabinet proper is made of a double wall construction, thoroughly insulated. The upper part contains retinned wire baskets for holding dishes. In the center shelf are large platters with covers for meats, while the lower shelf contains various size aluminum utensils for other foods. This particular wagon depends upon its insulation for maintaining the heat but it can be provided with hot water base equipped with steam coils or gas burners, or with electric heating units.

Figure 17 is essentially a steam table truck. The base is provided either with open shelves as shown or with sliding doors if so specified. The truck is originally designed for hot water heating, supplemented with steam connection or gas burners, but electric heating units can

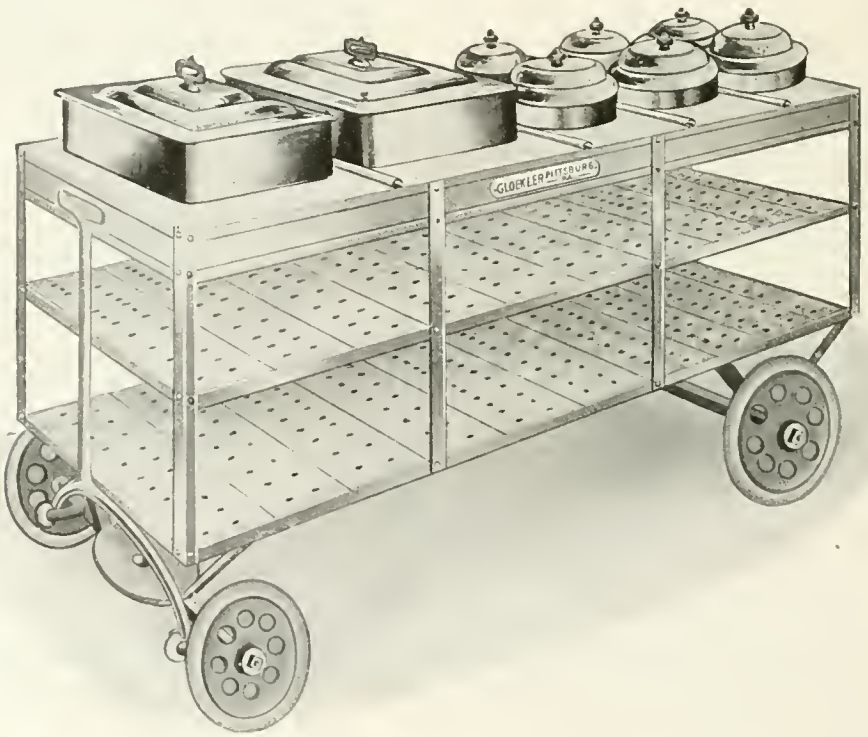


Figure 17.

also be supplied. The illustration clearly shows the arrangement of the top which conforms quite closely with customary steam table arrangement.

While it is possible to use these portable steam tables in wards for bedside service, their size and completeness better adapts them for use in the serving room or diet kitchen where connection can be readily made for steam, gas or electric heating.

Figure 18, however, is well suited for bedside service in wards. This is the steam table type utilizing hot water for heating, supplemented by a condensed fuel which is supported on two removable trays beneath the water. The adjustable shelf at one end is convenient in serving, and the lower compartment with sliding doors provides ample storage space for necessary dishes. The arrangement of the top follows the usual custom with meat tray with telescopic cover, and four aluminum food receptacles.

Electricity is gaining favor as a means of heating portable steam tables or food carts.

Figure 19 shows a large capacity food cart, provided

Figure 18.

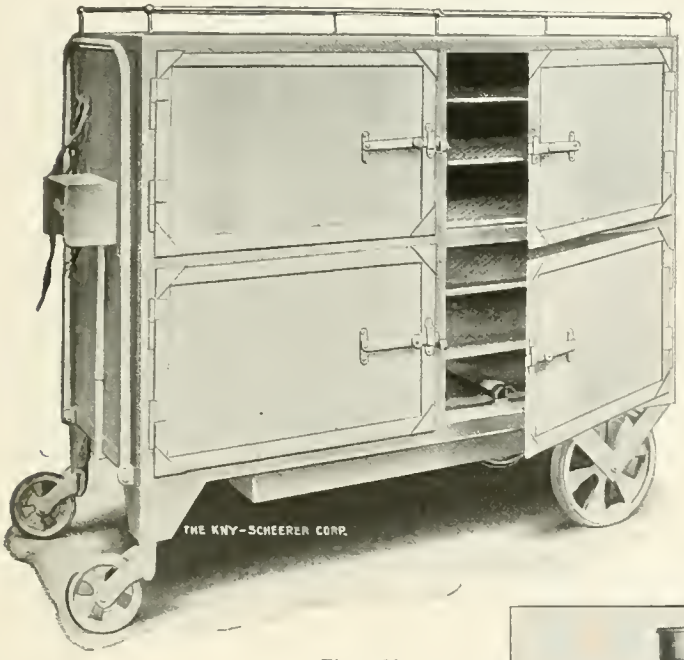


Figure 19.

with electric heating units. The cart itself is divided into compartments with five shelves. The heating element is at the bottom. It is suggested with an outfit of this kind to heat the truck thoroughly by attaching the heating units while in the kitchen, and then again to attach it to a lamp socket while the food is being served in the ward. This cart is designed solely for transportation purposes.

A convenient type of portable electric steam table is shown in figure 20. The top, of nickel silver, is equipped with an aluminum coffee urn, two meat pans with covers and four aluminum vegetable containers with gravy pan. This carriage is provided with hot water base with electrict heating units in addition, and while designed for bedside service, is equally suitable for serving room use.

Another type of electrically heated food carriage figure 21. is designed primarily for bedside service. The small upper compartment with drop door contains two three and three six-quart insets, together with a covered meat platter. The top is Monel metal, as is the sliding shelf. A convenient compartment with doors and shelves gives facilities for storing dishes and trays.

Probably the most complete type of portable food service is a recently designed service wagon (figure 22) equipped with electric heating units. This is essentially a heavy duty outfit, strongly constructed and completely equipped. The top section contains two large meat platters with telescoping cover and two vegetable containers, also equipped with telescoping cover, the latter divided into two compartments each, thus providing space for four different foods. These containers, and also the plate warming closet in the base, are heated by electricity; an upper shelf adds considerable convenience in service. The top of this cart is made of either Monel metal or heavy steel covered with nickel silver.

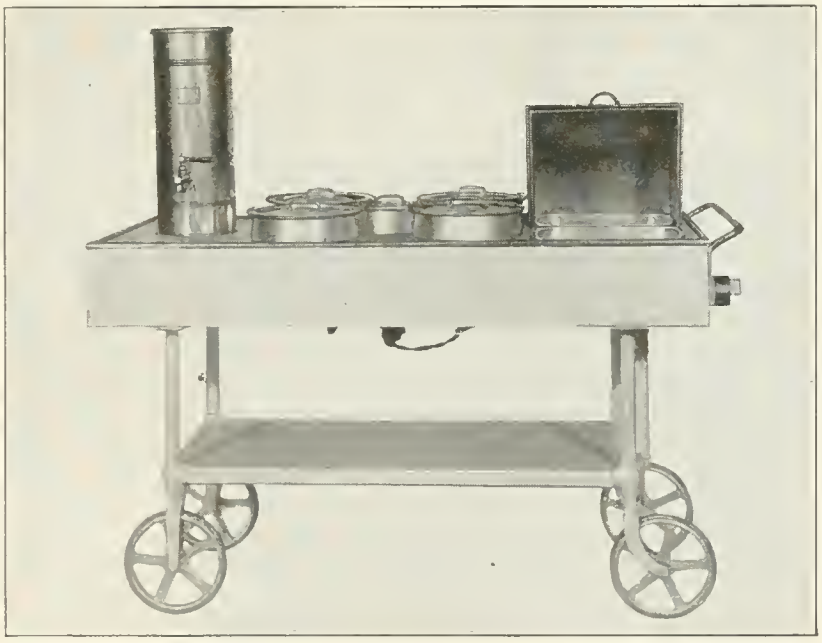


Figure 20.

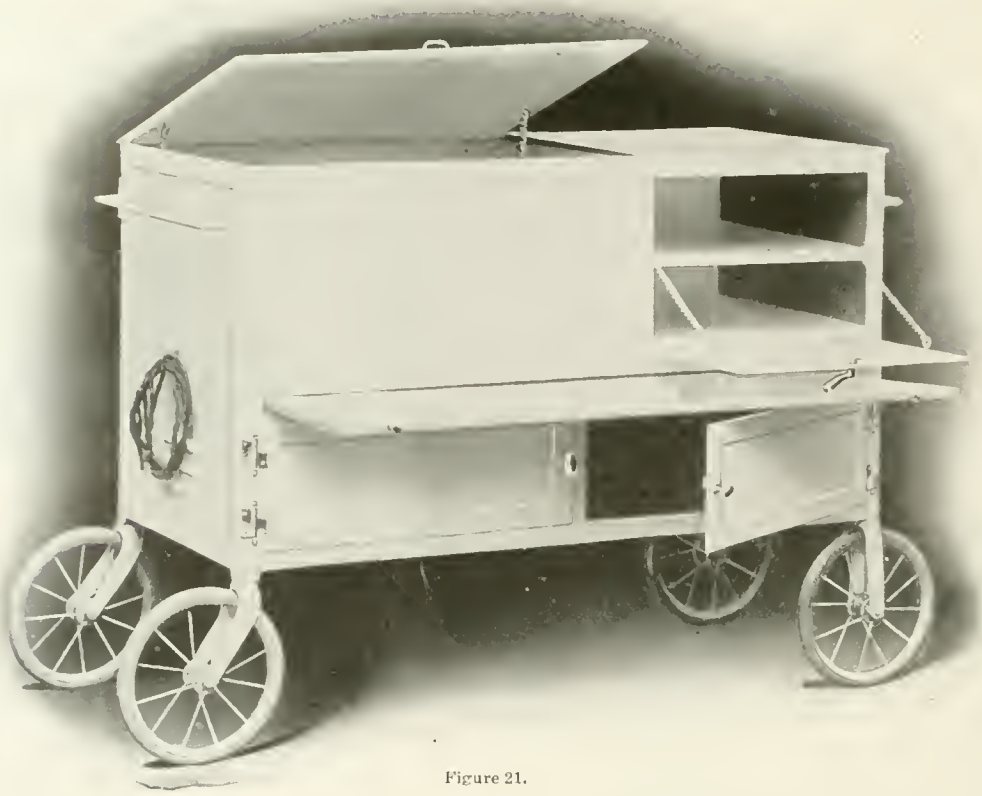


Figure 21.

As stated earlier in this article, it is impossible to attempt any standardization of food carriages or recommend any particular type for general use. There are certain outstanding facts which must be considered in the selection of equipment and these facts have to do primarily with the planned serving routine of each institution.

Where the hospital consists of outlying pavilions or cottages, provision should be made for very heavily insulated food containers, so that the heat can be largely retained. Such equipment can be arranged either for bedside service or merely for the transfer of the food to serving rooms.

In hospitals located entirely within one building, food service resolves itself into three general classifications.

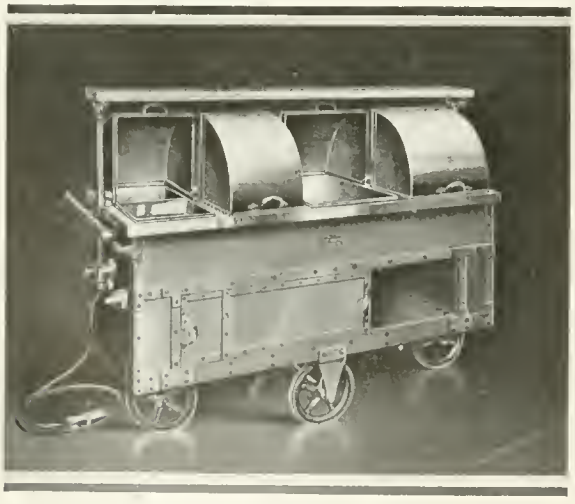


Figure 22.

Where bedside service is attempted, food carts should be selected that provide not only methods of heat retention, but also facilities for such service. A system of this kind would require a sufficient number of these carts so as to serve amply the entire institution and these would be centralized in the main kitchen and loaded direct from the range.

In some institutions tray service is used almost entirely with trays made up in the main kitchen. In such instances food carriages with insulated walls and preferably with hot water or some other heating element should be secured so that the trays may be loaded on shelves and distributed with a minimum loss of heat. According to such a routine, food carriages again would be centralized in the kitchen and the trays made up either from a range or from a special serving table. Such service would probably require a steam table in the central kitchen.

In many institutions service is handled from ward kitchens or serving rooms. To meet the requirements of such service, a food carriage designed like a steam table or service table should be installed. This should be equipped with connections for heating by either steam, gas or electricity. This suggested routine would call again for the centralization of these portable steam tables (so-called) in the kitchen where they would be filled direct from the range and then transported to the various serving rooms where connections of heating units would be made.

Conditions vary to such an extent, however, that in few institutions will one of the above suggestions be entirely adaptable, but will call for modifications or combination of the above suggested routine.

It might be added that additional provision, which would perhaps contemplate a small stationary steam table, must be provided for the service of the dining rooms for the staff and nurses.

LINOLEUM AND CORK CARPET IN THE HOSPITAL

NEW and improved methods of installation, together with recent improvements in manufacture, have demonstrated the desirability of linoleum as a flooring for use in many sections of the hospital. There are several general kinds or classes of linoleum peculiarly adapted to hospital floors. These are battleship linoleum, inlaid linoleum, linoleum tile and cork carpet.

All types of linoleum, speaking in a general sense, are manufactured in about the same manner and from the same raw materials. Cork is ground to a very fine powder, then thoroughly mixed with a linseed oil binder made up of oxidized linseed oil, rosin and imported gums. The necessary coloring pigments are then added. The composition, after it has been mixed, is pressed firmly upon a strong burlap base by heavy steel rolls or hydraulic presses. Inlaid linoleum as a rule contains wood flour instead of ground cork or in combination with ground cork.

Drying and seasoning of linoleum is an important step. It takes from ten days to two months, according to the thickness of the linoleum. The temperature of the drying rooms often is as high as 160 F.

Best Brands of Linoleum

The best brands of linoleum are those in which the mixing of raw materials has been thoroughly done, and seasoning has not been hurried. Thorough and repeated mixing insures a solid, firm piece of linoleum with a smooth surface. Slow, careful seasoning removes the danger of the linoleum being hard and brittle on the surface, and soft, mushy and moist in the center. If it has been evenly and carefully seasoned throughout, its life will be noticeably longer.

The hospital architect, superintendent, and building committee will naturally be interested mainly in battleship linoleum. Most of this flooring is manufactured in a dark brown color which has proved itself the most satisfactory under ordinary conditions. It blends well with any color scheme and can always be closely matched if additional quantities are needed. A third reason for the great popularity of brown linoleum is that it shows footprints to a minimum extent. It always looks attractive and clean.

Battleship Linoleum

This is a linoleum of very fine grade, noted particularly for its strength and durability. The name "battleship linoleum" does not apply to the product of any one manufacturer; it applies to a quality standard and implies that the linoleum meets the rigid specifications set by the U. S. Navy for linoleum which will withstand the terrific wear given the decks of battleships. Battleship linoleum (manufactured in several thicknesses and colors) has been found to be the most satisfactory for flooring in wards and corridors. It is easily cleaned and cared for, especially when the standard dark brown color is used. It possesses comfortable resiliency and springiness under foot and has sound-deadening qualities which are particularly valuable. Considering the fact that the thicker grades make a permanent floor, the cost is small, considerably less than hard wood, mastic or composition floorings. Many of the foremost hospital architects specify battleship linoleum throughout the hospital building, offices, dining rooms, private rooms and nurses' quarters, as well as wards and corridors.

In selecting linoleum floors, it is necessary to become familiar with the different thicknesses manufactured. Battleship linoleum is made in three grades: one-quarter inch, three-sixteenths inch, and one-eighth inch. These grades or thicknesses are ordinarily termed heavy, medium and light battleship respectively.

Often, however, a grade known as "six millimeter" or "commercial heavy" is to be found on the market. This grade is somewhat under one-quarter of an inch thick. Unscrupulous contractors have been known to furnish it when the specification definitely called for the genuine quarter-inch or heavy battleship linoleum which meets the rigid Navy specification, thus fraudulently increasing their profit out of the owner's pockets.

How to Tell Linoleum Quality

There is one sure way to guard against inferior linoleum being substituted. The United States Navy Department, large users of heavy linoleum for the decks of battleships, has drawn up a set of rigid specifications. See that your linoleum agrees with these navy specifications. This will frustrate any attempt to substitute inferior material. Specifications or orders for battleship linoleum floors should include this clause: "Linoleum to be full one-quarter inch, three-sixteenths of an inch, or one-eighth of an inch in thickness, according to specifications 29LIC, U. S. Navy Department, September, 1916, and shall in all other respects conform to these specifications."

The contractor should be required to furnish two samples of the linoleum to be installed; one of which should be retained for comparison with material actually delivered.

Inlaid Linoleum

In deciding upon floors for the many small and medium-sized rooms in the average hospital, due consideration should be given to inlaid linoleum and cork carpet. Inlaid linoleum makes a patterned floor, and there is an almost unlimited number of designs from which selection can be made. As the name implies, the design or pattern of this kind of linoleum is built through the entire thickness of the goods, and cannot be worn off. There are several thicknesses, ranging up to the heaviest type, which is approximately one-eighth of an inch from face to back. Although comparatively little inlaid linoleum has been used in hospitals in the past, it is well suited for small dining rooms and offices.

Printed Floor-Coverings

On the market are some patterns of printed linoleum and felt base floor-covering which are almost identical in appearance with those found in inlaid linoleum. In this kind of floor-covering the pattern is merely printed on the base and will wear off in a comparatively short time. Though these printed goods may be suitable for home or store use they will not stand the gaff of hospital use. Care must be taken that this cheaper and less durable product is not erroneously bought in place of real inlaid linoleum.

Cork Carpet for Extra Quiet

Where quietness is the main consideration, cork carpet has much to recommend it, for it is softer and even more resilient to the tread than the other linoleum products. These qualities are obtained by using a coarser grade of ground cork and by a different treatment of the linseed oil.

Most cork carpet (which comes in several different colors), is made about one-quarter of an inch thick. Lesser thicknesses may be obtained, but when made much less than one-quarter of an inch in thickness, the main characteristics, quietness and resiliency, are partially lost. Cork carpet, on account of its porous surface, cannot be cleaned quite so readily as battleship and inlaid linoleum, and its use, therefore, should be confined to floors likely to have a rather light traffic, and where absolute quietness is essential.

The resiliency and "give" of cork carpet cannot be found in any other of the floorings suitable for hospital use. It is, in fact, a specialized product. For quiet zones it is superior to battleship, inlaid and tile linoleum.

Linoleum Tile

Yet another type of linoleum floor is the floor of linoleum tile. Though comparatively expensive, this makes a good floor for waiting and reception rooms, passenger elevators, and other public rooms of similar nature. This floor resembles inlaid linoleum in its general effect. It is however, about twice the thickness of the best grades of inlaid. A range of about a dozen colors is possible, while the number of patterns is, of course, unlimited.

Hints on Buying

An important point to be carefully noted when receiving bids on linoleum floors is that the price named should be either for the square foot or square yard of floor area actually covered, or lump sum for the entire job. Otherwise, a price "per square yard of linoleum needed" is likely to be named. This involves a waste of four or five per cent, which is practically unavoidable when installing linoleum floors. But when a price "per square foot of floor area covered" is quoted, it means that the contractor, being forced to absorb all waste, will cut the waste to a minimum. The purchaser of linoleum, therefore, will do well to obtain goods manufactured according to Navy Standard, and then have his floors installed by a contractor who is willing to quote either a lump sum price or a price based on the actual footage of floor-surface to be installed.

It is possible to purchase linoleum that is guaranteed by the manufacturer to give lasting satisfaction and to have floors installed by contractors, who give a definite guarantee on their work. Dealing with such concerns, even at a slightly higher price, is naturally much to be desired.

Proper Laying Very Important

To insure a permanent and satisfactory linoleum floor, its installation must be properly made, just as is the case with practically all types of floor construction. In new hospital construction, linoleum is often cemented directly to the concrete floor base. This will make a satisfactory floor provided that a high-grade, waterproof linoleum cement is used, and, further, that the concrete floors are entirely free from moisture. Installing linoleum over a "green" concrete base is never practicable, even though the base is first treated with some efficient waterproofing material. Linoleum should not be laid until all the moisture has dried out of the floor.

Linoleum can also be readily installed with cement on wood floor bases in new construction or over old wooden floors in buildings being renovated. The essential points are to make sure that no moisture is present and that all floor bases are made smooth before the linoleum is installed.

A heavy felt or building paper is sometimes laid over the sub-floor, and the linoleum then laid over the felt. Each material is tightly cemented to the other. Certain advantages are claimed for this method of installation, particularly in the case of wood floors.

If necessary, linoleum may be laid over practically every other kind of floor, but it is highly recommended that the hospital architect seek the advice of a leading linoleum floor contractor before specifying such work, since exceptional conditions might require special methods of installation. Under any circumstances it will pay to have installation made by a thoroughly experienced linoleum contractor, who can point to other satisfactory jobs completed as evidence of his workmanship.

Proper Care of Linoleum Floors

Strong caustic or alkali soaps should never be used for cleaning linoleum, inasmuch as they cause disintegration of the material. The proper way to clean linoleum is with mild soap, preferably a vegetable soap and tepid water. Small areas should be done at a time, mopped first with soapy water, then with clear water (using always only a minimum amount of water and never "flooding" the floor), followed with a brisk, speedy drying.

Waxing and oiling prolong the life of linoleum. Any of the regular oil and wax preparations on the market may be used. An application every two or three days, after the linoleum has been swept and cleaned, will be found to keep the colors bright and the surface nicely polished and protected.

When linoleum is subjected to heavy wear, a varnishing once or twice a year will be found practical, although tending to reduce the resilient quality of the linoleum. It will cover the linoleum with a protective surface and prolong its life. It is not necessary to wax or oil linoleum that has been varnished, unless a very high brilliant finish is desired. Linoleum that has been oiled, however, should not be varnished.

Inlaid linoleum and cork carpet may be treated in just this way with one exception—cork carpet must not be varnished. Its chief charm is its softness and resiliency. Varnishing would harden it, and is, therefore, neither desirable or advisable.

HEALTH TAX UP FOR DISCUSSION

A very extensive propaganda for a health tax in British Columbia has been carried on, so successfully that the new legislature which will convene in January will seriously consider the adoption of such a measure in the province of British Columbia, it is hoped. During last year a Health Commission made a survey of the province and its report will come up before the legislature. It is also rumored that a Ministry of Public Health in the province of British Columbia will be appointed, and it is assumed by several in authority that hospitals may be transferred later into this department. However, the future promises to bring with it considerable development of a new policy for our institutions.

Never let your love for your profession overshadow your religious feeling. Depend on it that religion will strengthen, not weaken, your energies, and will not only make you a better sailor, but a superior man. Professional studies are not to be neglected; but, on the other hand, take care how you fall into the common error of believing that they are the remedy of all the ills of life.—B. R. Haydon.

HANDLING CRACKED ICE IN THE HOSPITAL

ONE of the details of hospital administration to which the principle that "anything that is worth doing at all is worth doing well" may be applied with profit, is the handling of cracked ice. Some superintendents are not satisfied with their method. If you are among them you may find it worth your while to know how some other hospitals who have written us on this subject, handle the problem.

From Dr. John Bresnahan, who, as our readers know, went from the American College of Surgeons not so very long ago to become superintendent of the Bridgeport Hospital, Bridgeport, Conn.:

"In some of the wards the nurses used a hand ice-cracker which made a terrible racket. In other wards, they used a canvas bag and a mallet to break the ice, with the result that at two o'clock in the morning a number of patients would be awakened. It was found also that the damage done to the ice boxes with the ice pick, and to sinks where ice was broken, as well as to rubber ice bags, make it necessary to find a practical method which would stop the wastage of ice at forty cents per hundred pounds, as well as save the above named equip ment and avoid the careless use of the ice pick wielded by special nurses who were not always under good hospital discipline.

Cylindrical fireless cooker used as cracked ice container at the Bridgeport Hospital, Bridgeport, Conn.

"The problem was first solved by having the ice cracked and shaved in the ice houses and distributed to the wards in buckets—the ready cracked ice being placed in the upper compartment of the ice box; but it was found that after eight or ten hours, this was fairly well melted.

"The next step in the experiment solved the problem: We secured a number of low priced cylindrical fireless cookers. The usual two compartment food container was replaced by a single ten quart container and each afternoon these containers are filled with the cracked ice by the ice man, and, providing the nurses keep the cover on after taking ice from the container, the cracked ice lasts until the following day."

From Dr. C. W. Munger, superintendent, Columbia Hospital, Milwaukee, Wis.:

I believe that the use of fireless cookers as ice containers would be very successful and a very good arrangement to install in an old building which has no ice containers built in.

"I am sure that I prefer the type which we have, which is an insulated drawer at the bottom of each refrigerator. These drawers are drained so that such water as collects from melting is disposed of. Lying in water does not accelerate the melting of ice unless warm water is being introduced, but the presence of water renders the handling of the ice somewhat difficult.

No Ice Should Be Cracked on the Floor

"I agree with Dr. Bresnahan that no ice whatever should be cracked on the floor where patients are housed. A central machine for cracking ice does the work much better at perhaps one-tenth the expense if the value of nurses' time is considered.

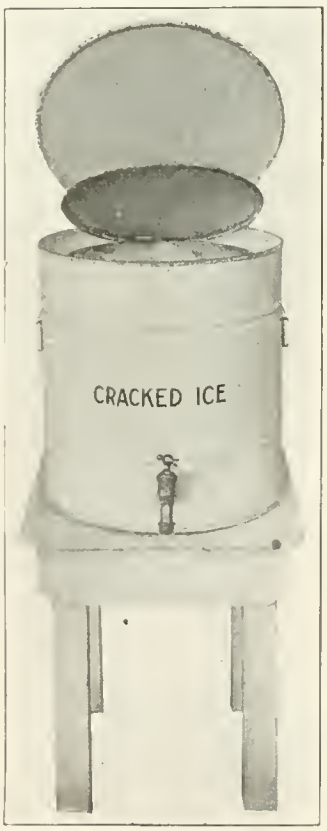
From Dr. L. A. Sexton, superintendent, Hartford Hospital, Hartford, Conn:

"It is pretty generally recognized that anything that is worth doing at all is worth doing well. I do not know of any small detail to which this is more applicable in hospitals than the handling of cracked ice.

"It is necessary that this be properly handled if we are to save our ice, our hospital property, the good disposition of our nurses and their time. If a sufficient supply for use day and night is not furnished through the proper channels it is then necessary for the nurse to crack it as best she can. We are all more or less familiar with the results when this method is used.

Proper Type of Container First Consideration

"The first consideration in the handling of cracked ice is the proper type of container for the wards or service rooms. The containers which we use (shown below) were made by our own force at a very reasonable cost and have been very satisfactory. The principle is a pail within a pail and the intervening space insulated with sawdust. The inner chamber is made of heavy galvanized iron (22 gauge), has a diameter of fourteen inches and is sixteen inches deep. When filled it holds sixty pounds of cracked ice. The outer shell, also made of galvanized iron, has a diameter of eighteen inches and is nineteen inches deep, with a wire edge top. As will be seen from these dimensions, when the inner shell is in position there is a two inch space on all sides and at the bottom. This is filled with dry well cured sawdust. This brings the top of the inner shell to within one inch of the top of the outer shell. The purpose in having the inner shell one inch lower than the outer is twofold. First, there is a collar soldered from the top of the outer shell which slopes down and is soldered watertight to the inner shell. This serves as a drain and protects the insulation. Secondly, the one inch dead space between the two tops prevents the ice from melting. We find it necessary to fill containers of this size twice daily.



Cracked ice container used at the Hartford Hospital, Hartford, Conn. This container is made by the mechanic of the hospital at a reasonable cost and has proved very satisfactory.

"The second consideration is the best type of machine to use for breaking the ice. There are all kinds and sizes of ice breaking machines on the market. The best type will depend altogether on the amount of cracked ice an institution uses daily. We use a power driven "Creasey." These are supplied with a tight and loose pulley and can be connected to any shaft or motor driven.

"The third and last consideration is the best type

Conveyor used in supplying ice to different parts of the Hartford Hospital.

of conveyor to use in supplying ice to different parts of the hospital. It is desirable that whatever type is used be water-tight, except for the drain, so that the 'ice man' cannot be traced from floor to floor by leakage and ice scattered along the way. We made a box for this purpose about four years ago that has been very satisfactory (as shown above). This box is made of one and one-half inch cypress material lined with twenty gauge galvanized iron, has metal corners and rim. It is mounted on three eight-inch ball bearing rubber tired castors. The front wheel in addition to being ball bearing is ball swivel. The box is twenty-four inches wide, inside measurement, twenty-four inches deep, and forty-four inches long and holds 410 pounds of cracked ice.

"In the Hartford Hospital, where we handle approximately ten thousand patients annually, this work is done by one man. His duties consist of filling the cans in the ice plant, drawing, breaking and distributing the cracked ice and keeping the hospital supplied with filtered water."

From Mr. Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, Ohio:

"We have a central ice breaking machine, the Creasy, that is located in the ice storage room, and from which cracked ice is distributed by a representative of the dietary department, three times a day in the summer time, and once a day in the winter time.

"We have a special cracked ice receptacle in our ward ice boxes. I am not so sure that that is the ideal installation. For one who could afford it, a cracked ice receptacle in the utility room would probably be preferable."

Dr. Babcock Has Refrigerating Plant

From Dr. W. L. Babcock, superintendent, the Grace Hospital, Detroit, Mich.:

"1. The hospital has a twenty-five ton refrigerating plant and manufactures all the ice used in the main hospital and the west side branch hospital, which is managed as a branch.

"2. Ice is pulled from the freezing tanks once daily and stored in a cooler room. An ice crushing machine driven by motor is maintained at the entrance of this cooler house. Any quantity of cracked ice can be provided in a few minutes.

"3. The cracked ice which is manufactured from distilled water is distributed by the porter to refrigerating boxes, refrigerated by the ice machines. This cracked ice is used for cold drinks and for ice bags.

"4. We have had manufactured for our ice boxes, which are seventy-two by forty-eight by twenty-six inches in size, a square heavy galvanized iron box with rolled edges. This receptacle for cracked ice occupies the bottom compartment in each refrigerator. With the box we have an aluminum or heavy tin scoop for dishing out cracked ice.

"5. No cracking of ice is permitted in any wards or corridors."

From Dr. Renwick R. Ross, superintendent, Buffalo General Hospital, Buffalo, N. Y.:

"Our ice is made from distilled water, it is then cracked into pieces about one inch square by a 'little giant' ice cracker. It is transported twice daily to various refrigerators and kept in square receptacles with perforated bottoms."

Kept in Sliding Iron Boxes

From Dr. W. G. Nealley, superintendent, the Brooklyn Hospital, New York City:

"Our ice for drinks, ice bags, etc., is delivered twice a day to the diet kitchens of the wards, where it is kept in sliding galvanized iron boxes which fit in the lower section of the refrigerators. We had an ice breaking machine but it was not satisfactory and at the present time the man who delivers the ice cracks it with an ice chopper before taking it to the wards."

From Mr. E. S. Gilmore, Wesley Memorial Hospital, Chicago, Ill.;

"At this hospital we have ice in a compartment of our refrigerator. Near it is an ice crushing machine, run by motor. The orderlies have pails, built on the plan of a fireless cooker, which they take to the refrigerator when in need of cracked ice. They break up the ice with the ice crusher and carry the pail to the ward needing it, where, because of the make of the pail, the ice does not melt readily. The nurses fill their ice caps from the pails."

Ice Man Delivers to All Wards

From Dr. Harold W. Hersey, superintendent, New Haven Hospital, New Haven, Conn.:

"In the New Haven Hospital ice is produced in our own plant. A supply is stored in a large central ice box located in the general kitchen and pastry room in a room housing the ice cream freezers and ice cracking machine. From this central point the wards and other departments are supplied by the ice man.

"The cracked ice used throughout the hospital is cracked in this room by an electrically driven number four Champion ice cracking machine.

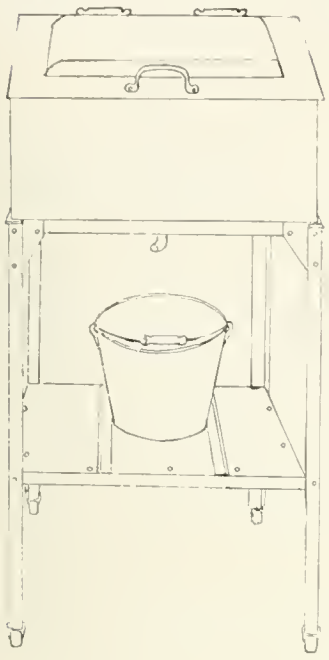
"A quantity sufficient to supply the wards is prepared and washed each morning and loaded aboard a metal lined box truck which visits each ward. From this truck a twelve quart galvanized iron pail is filled and placed in the ice compartment of each refrigerator, where it is available for use in ice caps or for other purposes. This method reduces wastage appreciably and allows the use of ice for refrigeration.

"Later in the day, or about 4 p. m., another supply of cracked ice is made as above indicated, and distributed to the wards in the same manner. These two deliveries, with the exception of a few days in summer, is sufficient for the twenty-four hours. In extremely hot weather our deliveries are made three times a day.

"A key to the central ice box is kept in the training

school office, where it is available day or night to meet any additional need for ice; but such needs arise very rarely."

A cracked ice container that is economical and satisfactory has been devised in the workshop of Grant Hospital, Columbus, Ohio. It is made of 26 gauge galvanized iron, 13½ inches wide, 20 inches long and 9 inches deep. The inch space between the two boxes is packed with cork shavings. The lid is also double with cork shavings between. The trap at the bottom is made of three-eighths inch galvanized pipe to keep the air from circulating.



"The illustration of our cracked ice container largely speaks for itself," says Miss Mary E. Jamieson, superintendent, "as it is made in our own workshop. We have them on every floor and would not be without them. Our refrigerators keep much cooler since we do not have to open them frequently to get cracked ice. The ice is brought from the ice plant, cracked, thus preventing any noise on the floor."

HOW DO YOU TEST YOUR FLOUR?

There is a natural tendency on the part of hospital dietitians and other individuals in charge of the preparation of foods to take flour pretty much for granted. This may be a perfectly safe procedure as regards many standard makes of flour, yet every purchasing agent, particularly every dietitian or chef, should know some of the simple tests by which all flours may be tested.

In trade circles flours are generally divided into two classes, soft wheat and hard wheat flours. In determining quality the grading is along the line of purity with respect to bran, germ substances and other refuse. Generally accepted, the main grades of flour are:

Patent flours—high, short or fancy; standard; long.

Straight flours—full, regular or standard straight; cut straight; stuffed straight.

Clear, or bakers' flour—first clear; second clear.

Low grade, red dog.

These terms have only an incidental value to the baking or culinary properties of flour or to its nutritive value.

Patent flours are from the central portions of the kernel and are very free from refuse. A short patent is supposed to be composed of a smaller and more select portion of the flour than long patent, and standard patent is between the two grades, the grade being indicated by a percentage.

Clear grade flour is composed of that flour producing portion of the kernel which remains after the patent has been removed and naturally contains a considerable portion of refuse.

Straight flour is composed of the entire flour producing portion of the kernel. A "cut straight" is one which lacks some of the purest strains of the mill run. A "stuffed straight" is one to which some clear or low grade flour from another wheat or another mill run has been added.

So much for the grading of flours. The most satisfactory and the most natural test of flour is to bake it in the form in which it is desired. There are, however, other indications from which a comparatively accurate gauge of qualty can be made. These indications include the color, odor, taste, feel and granulation.

Whiteness in flour is not always an indication of superior quality. In many instances whiteness indicates inferiority or the use of a bleaching process in manufacture which may be detrimental. In the early days of the milling industry, when manufacturing processes were much more simple, white flour could only be produced from the central portions of the wheat kernel, and for this reason whiteness in flour indicated possibly greater quality.

In modern methods of milling, however, the waste can be separated from the outer portions of the wheat and can be made as white as the heart flour, so that today whiteness can only be considered as showing freedom from refuse.

Bleaching processes are sometimes used, but such methods are not always in accordance with existing laws and in all cases bleached flour must be so labeled.

Hard wheat flours have a natural creamy or yellowish white color. A gray ash color is supposed to indicate refuse matter, and this can often be determined through the use of a magnifying glass, which shows the refuse matter clearly as black specks.

Good flours should have an odor and taste like freshly ground wheat. There should be complete absence of sourness and disagreeable odors.

When squeezed in the fingers, good flour falls apart easily, but retains the impression of the fingers. This method is a good way of distinguishing hard and soft wheat flours, as hard wheat flour falls apart more readily.

Flour should not contain so much moisture as to form pellets when rolled in the hand. Dampness can be detected by thrusting the hand into a quantity of flour.

Good flour should show some slight grittiness when rubbed between the fingers; one should also be able to detect this with the teeth. This characteristic is generally more noticeable in hard wheat than in soft wheat flours.

The crumbs from baked loaves is one of the best indications of the quality of flour.

The strength of flour can best be determined when mixed with about half its weight in water and thoroughly kneaded. A strong flour will produce an elastic dough, which will hold its shape and will not stick to the fingers, while weak flour will give a sticky dough which does not hold its shape.

It might be well to state that it is almost needless to test standard makes of flours made by reputable millers, whose effort has always been directed toward standardization in both methods and products.

CONDENSED ORANGES

A California concern has recently perfected a process by which the essential components of the orange can be delivered to the consumer in small cubes. From these cubes it is said jelly or marmalade can be made at a cost of one-third of the present retail price. Moreover, it is claimed that the use of these cubes will produce a better brand of jelly or marmalade than is generally offered.

This process utilizes the by-products of the orange groves, oranges which are not in condition to be marketed at a distance being utilized in the making of these cubes.

SPEEDS UP HOSPITAL PAINTING

Painting in the hospital has become more or less of a routine job. In fact, in some of the larger institutions a force of painters is kept busy almost the entire year, renewing walls. The necessity for frequent repainting in the hospital is obvious. Not only is it necessary to keep the building attractive, but frequent cleaning of both walls and woodwork undoubtedly hastens the need for repainting.

One of the big problems in every hospital, whether large or small, is to get this painting done as quickly as possible. In the last few years almost every hospital has been taxed to its capacity, and it is difficult to spare a ward or room long enough to have the necessary painting completed.

For this reason hospital executives should be greatly interested in power painting by which the paint is sprayed

A portable outfit for power painting makes the redecorating problem in hospitals much less burdensome.

on the wall surface by means of compressed air.

This method has been largely used in industrial plants where stationary installations are employed in the finishing of various products. A portable outfit is now marketed, however, which makes this equipment readily adaptable to hospital requirements. The portable outfit for hospital use consists of a hand truck on which are mounted an electric motor, air compressor and air tank. The operation of this equipment is fairly noiseless. The compressed air is carried by pressure tubing to a smaller container mounted on casters which is shown on the floor in the illustration. The air pressure forces the paint through the hose to the "spraying gun" where it is under the constant control of the operator.

The advantages of power painting are numerous. Not only does it paint at least five times faster than hand brushing, but it uses less paint and eliminates waste. The operator, furthermore, is able more easily to reach places difficult of access, for the paint sprayed on under air pressure forces its way into every crevice, insuring a more perfect and sanitary job. Particularly is it far easier to paint over-head surfaces by this method. When applied under power the paint is sufficiently distributed, and laps and brush marks on the surface are prevented.

The air pressure outfit can be used with a wide range of paint materials, including oil paint, enamels and flat wall paints, either water or oil.

The outfit is extremely easy to install and can be connected with any electric light outlet, thus making it adaptable for use in every part of the building.

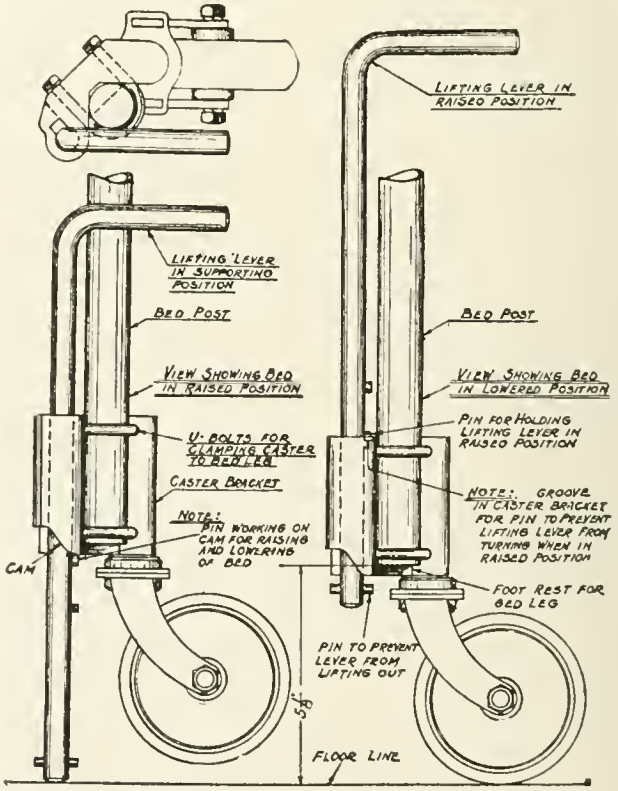
Inasmuch as this outfit enables an operator to cover 500 or more square feet in an hour, it can easily be seen that the average private room in the hospital can be completely refinished in a comparatively short time and be again ready for occupancy.

NEW CASTER MEETS NEED

One of the big objections to the use of casters or wheels on hospital beds and operating tables has been the difficulty in so locking the casters so as to make the bed or table absolutely rigid. Effort has been made to accomplish this by means of brakes on the casters themselves, but, as a rule, these have not proved thoroughly dependable. Certain manufacturers have also offered devices by which the bed or table posts are extended, raising the caster off the floor and anchoring the furniture securely. Such equipment must be "built in" to the bed or table and is practical only in original installations.

A new caster set is now being marketed by an established manufacturer of casters and wheels which apparently has many advantages over the others. One of its essential features is that it can be attached to beds or tables already in use and which are equipped with ordinary caster without a locking device.

By the use of U-bolts, the caster set is securely clasped to the leg of the table or bed. The caster proper is of high class manufacture. The rubber tired wheels are four inches in diameter and are mounted on a machined bearing that not only insures easy operation but continued dependability. This bearing overcomes the difficulty that many institutions have found in caster sets, as it is so carefully mounted there is no chance for excessive wear or binding.


LIFTING LEVER IN RAISED POSITION
LIFTING LEVER IN SUPPORTING POSITION
BED POST
VIEW SHOWING BED IN RAISED POSITION
U-BOLTS FOR CLAMPING CASTER TO BED LEG
CASTER BRACKET
NOTE: PIN WORKING ON CAM FOR RAISING AND LOWERING OF BED
CAM
BED POST
VIEW SHOWING BED IN LOWERED POSITION
PIN FOR HOLDING LIFTING LEVER IN RAISED POSITION
NOTE: GROOVE IN CASTER BRACKET FOR PIN TO PREVENT LIFTING LEVER FROM TURNING WHEN IN RAISED POSITION
FOOT REST FOR BED LEG
PIN TO PREVENT LEVER FROM LIFTING OUT
5½"
FLOOR LINE

Cut at the left shows caster raised from the floor with weight resting on lifting lever. Cut to right shows lifting lever raised and weight resting on caster.

As the illustration shows, the locking device consists of a lever which can be dropped through the head casting. The lever is given a half turn and a lug or pin working on a simple cam elevates the bed or table about one-half inch from the floor and anchors it securely.

The simplicity of this device, combined with the sterling qualities of the caster construction and the fact that it can be adapted to furniture already in use, should make it an extremely useful as well as economical caster for many institutions.

BLANKET FACTS

The purchase of blankets in the hospital is a serious problem. Not only do such purchases reach a considerable volume in the course of a year, but there is a serious lack of expert information on the subject. This lack of definite information on blanket quality is not confined to hospital executives, but is very apparent in the purchasing for hotels and similar institutions, and likewise in many mercantile establishments.

This statement does not reflect on the buying acumen of hospital executives or on their intelligence or keenness. On the contrary, blanket quality represents one of the most difficult problems to solve, even by experts.

It is almost a universal custom to buy blankets solely by weight, size and material. Even when it comes to material there is great uncertainty. The recent high prices for materials entering into blanket making, combined with the existing lack of technical knowledge on the part of the buyer, has resulted in the widespread marketing of blankets, presenting all outward appearances of quality, but lacking in those elements necessary for blanket satisfaction.

This decision has reacted against those firms selling blankets of acknowledged quality and in many instances has made the buyer unduly suspicious of the products of all concerns. It is hoped that these unfortunate experiences in which many hospitals have shared will prevent the undiscriminating purchase of blankets in the future.

The United States Government has recognized the difficulties in determining blanket values. The national bureau of standards, Washington, D. C., has devoted considerable research and study to the testing of textiles, including blankets. The results of their tests are available to all buyers. In fact, institutions or firms purchasing large quantities of blankets will be amply justified in submitting samples of the blankets they are considering to the bureau of standards and have an authoritative test made of the relative quality of the various samples.

It is obviously impossible for the everyday institution to submit samples of their blankets purchased for laboratory tests. There are, however, certain established conclusions which should aid them in making their selection. There are certain fundamental factors which must be considered in judging a blanket's usefulness for institution use. These factors include warmth, strength, thickness and fibre content. If the buyer will judge the sample blankets from the standpoint of these essential factors, he will be able to reach a more logical and intelligent conclusion.

The fundamental quality of the blanket is warmth. This means that the value of a blanket as protection against cold lies in its ability to prevent the passage of air through the blanket. Scientific tests in which the amount of heat transmitted through various materials was measured, brought out these facts.

Heat retention is not dependent upon weight alone.

Heat retention is not dependent upon the fibres used.

Heat retention is not dependent upon thickness alone.

The greatest determining factor affecting the imperviousness of a blanket is the arrangement of the fibres.

From these facts it is readily seen that the actual heat retaining qualities do not depend on whether a blanket is made of wool or cotton, but rather upon its construction. Even casual examination of blanket samples will enable the buyer to determine relatively which sample is least impervious to the passage of air.

It must be remembered, however, that this is only one factor to be considered. The warmest blanket, i.e., the blanket wth the great heat retaining qualities, is not always the strongest or the most durable blanket. The so called "napping" process naturally reduces the strength of the blanket to some extent, because the surface of the yarn is broken to form the nap. It is readily seen, therefore, that the desirable blanket is one that combines wearing quality and heat retaining quality in such measure that too great a sacrifice of one has not been made to enhance the other.

The strength of a blanket is determined primarily by the tensile strength. This can not be accurately determinded without a proper measuring device. Even casual testing of this factor will be of assistance to the buyer, and will enable him to avoid the purchase of blankets lacking proper strength to a marked degree.

The thickness of a blanket must be considered in connection with its warmth and in such consideration thickness and weight are almost synonymous. The purpose for which the blanket is to be used, climatic conditions, the temperature of the room, must all be considered when deciding upon the thickness of the blanket to be purchased.

It may surprise many to learn that wool and cotton blankets can be made equally warm and strong if properly constructed. There has been a tendency to regard wool blankets as necessarily representing a higher quality than cotton or part cotton blankets. This fact does not necessarily follow; everything depends upon the length of fibre, the method of construction, and the imperviousness of the fabric. Do not, however, understand us to say that there is no difference in the value of wool and cotton blankets. If both are equally well constructed there is a difference and this difference lies mainly in the resistance to the wear and tear of laundering, which affect different fibres in different ways. Frequent laundering is apt to destroy the effective heat retaining qualities of the blanket by destroying the nap and likewise decreasing the strength of the blanket, and in this respect cotton blankets frequently prove inferior to wool or part wool blankets.

It is not within the scope of this article, however, to discuss the relative merits of cotton and wool blankets, but rather to discuss those essential facts important in the purchase of either.

The purchase of blankets in the hospital must frequently be figured from the standpoint of cost, which will affect the decision as to the kind of blankets purchased. Even this condition, however, should not prevent the buyer from securing the best blankets possible for the available money.

Occupational Therapy and Rehabilitation

Conducted by HERBERT J. HALL, M.D., President, American Occupational Therapy Association, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

CHRISTMAS AT THE MILWAUKEE CHILDREN'S HOSPITAL

"How many days until Christmas?" "May I write a letter to Santa Claus?" "Will my mat be finished to give to mother on Christmas?" "Will Santa Claus come in an aeroplane?" How many reindeer has Santa Claus?"—these are the questions that are uppermost in the minds of our little patients from the time when cold December makes his appearance until Santa has emptied his pack and the last tinkle of his bells has died away. For Santa Claus comes every year, a jolly, jingling, dancing, old fellow, giving his toys to each patient and listening to their Christmas greetings and songs.

Many a poor child, while sick at the hospital, obtains his first conception of the spirit of Christmas and the fulfillment of his most cherished dreams. To see the eager faces at the windows waiting for Santa Claus, to hear the first shrill voice cry, "There he is!", and to watch the puzzled faces as Santa, by mistake, ascends the steps leading to the house across the street—then the shouts of joy as a nurse leads him to the hospital door is more than thrilling to the interested spectator.

After Santa Claus has made his visit, Milwaukee Children's Hospital.

There was an abundance of Christmas cheer at the last celebration. Besides all the gifts for each individual child, Santa Claus presented the children with a Victrola bought under favorable conditions from the sale of articles which the patients made during the year. The little ones hope that by being good and industrious, Santa Claus will present them this Christmas with another gift as enjoyable as the Victrola.

So it is with eager anticipation, increased by oft-repeated stories of last season's happenings, that the children at the Milwaukee Hospital await Christmas of 1921.

THE CHRISTMAS SPIRIT

The writer has always been a little troubled by the Christmas Spirit—it is so soon over. For weeks the Salvation Army lassies stand out on the cold corners collecting money for one good hearty Christmas dinner to satisfy the hunger of thousands for one day. All delightful and appropriate, but what about the other three hundred and sixty-four days? We cannot feed the world out of our charitable pockets. We cannot provide a continual Christmas feast even for the poor and helpless. The communistic idea is very attractive, but many sad experiments have shown that it is not practical. "If any would not work, neither should he eat" is a hard saying, but there is a deal of justice and necessity wrapped up in it. The dictum is derived from principles which in the main are right, and essential for the welfare of the world. Let us have the Christmas Spirit by all means, let us sing our carols, hang our wreaths, and fill up the empty stomachs, but those who think seriously and who wish to do their part in the service of humanity will be considering the other three hundred and sixty-four days, and the very great need of appropriate work for all but the actually helpless.

The great problem of adequate work for the millions is in the hands of our statesmen and our captains of industry, and it is a matter hedged about with world old difficulties. In the presence of these problems, our little O.T. project of work for the handicapped seems small indeed, but it is a business that appeals particularly at this Season of Goodwill. Occupational therapy with its first halting steps in the retraining of the injured, the crippled, and the chronically ill, seems to us now, as we think of it, a very wonderful gift to the world of need. Surely, the charity that helps the handicapped

to help themselves is worthy of all praise and full support.

Those of us who are concerned with this very appealing phase of human helpfulness know that we have taken hold upon a very big idea, which, carried out to its fullest developments, can mean nothing less than the harnessing up of handicapped effort everywhere. We know that if, in the future, we are able to provide the materials and the supervision, we shall succeed finally in coordinating the manufacturing possibilities of thousands of otherwise helpless people, until the sum total will become a matter to be reckoned with, not trivial at all, but a very substantial step toward the feeding and housing of thousands who might be hungry or homeless during those desperate three hundred and sixty-four days.

Occupational therapy first, then handicapped labor, organized, directed, and if necessary, subsidized. Infinite possibilities lie that way, not only a real contribution toward the material relief of the helpless, but the possibility of courage and self-respect, where these very precious elements have not existed before. If well-directed, productive energy is necessary for economic salvation of the race, then perhaps the example of the handicapped doing their part will help to shame the slackers and put them about their legitimate business.

Occupational therapy and rehabilitation are good for most of the year—we will not ask anyone to work except for pleasure on Christmas Day.

OBJECTIVES AND MOTIVATION IN OCCUPATIONAL THERAPY

By ALLAN R. CULLIMORE, Formerly Major in the Sanitary Corps, United States Army, and Chief of the Educational Service in Letterman General Hospital, San Francisco, Cal.

Occupational therapy planned to kill time is good in its place, but it stands in the same relation to the real occupational therapy as that of first aid to medical treatment based on examination and careful diagnosis. The occupational work must be founded on a thorough examination and enlightended diagnosis and must have a definite end in view. Moreover the patient must desire this end. The examiner after he has determined upon the end must see that all work leads definitely toward it and that every worker coming in contact with the patient understands what the objective is. One should be slow to change the objective but once changed there should be no hesitancy in its pursuit. Mr. Cullimore has found this lack of motivation and objective to be the most noticeable defect in the work of many hospitals of the United States and Canada.

WHILE the immediate functions of occupational therapy are well understood and widely recognized and while from an immediate therapeutic standpoint its efficacy is beyond question, the ultimate objective is frequently lost sight of, or at best is but hazily appreciated. It will, of course, be understood that the treatment accorded any patient in any hospital has for its goal the reconstruction of the individual to the point of highest possible efficiency. Immediately considered, this efficiency is physical and the means employed, be they medicine or surgery or both, are concerned directly with physical wellbeing. In a broader and a deeper sense, however, the functions of the physician and the surgeon are of greater significance. In addition to immediate physical well-being, whether it be recognized or not, the doctor has a responsibility which has to do with the economic, the social and the moral, as well as the physical behavior of the patient who passes under his care. And if, as has been proved, occupational therapy is a definite therapeutic agent, and if as such an agent it is really valuable, it must share responsibility ultimately as well as immediately with the physician and the surgeon.

It will be clearly seen that in cases of major amputations and in certain mental cases, the results of treatment must be specific rather than general. It would manifestly be impossible if the amputation of an arm were indicated to so perform the operation as to make the patient in a general sense as efficient as before, neither could the surgeon perhaps operate in such a way as to make it possible for the patient to take up his occupation as a machinist. It might be possible, however, for the man ultimately to become a draughtsman. It would seem better practice to work to a definite objective in many cases rather than to a broadly generalized one.

This is particularly true in the case of occupational therapy, that is in the treatment of individual cases by this agent. Physically in most cases the diagnosis has been made and the treatment fixed in so far as it relates to the various forms of therapy, very probably the character and the duration of the periods of occupational therapy have been also fixed, and in very many instances the occupational guide merely fills in with "busy work" certain periods that would otherwise be spent in soltaire, letter writing or worse. While this sort of occupational therapy is perhaps not positively bad, it is certainly negatively good and falls so far short of what ought to be done, and what can be done, that it often merits the disapproval which is given it by certain enlightened medical men.

It is doubtless true in the treatment of many cases by occupational therapy that work of the generalized or "busy work" should be given. It is true in exactly the same sense that a patient must live to be treated, and while first aid treatment is calculated to keep the patient alive until he can be put under treatment, and is therefore important, it would be criminal to consistently apply first aid in lieu of a treatment based on a thorough examination and an enlightened diagnosis.

When a patient comes under the influence of a man or woman for treatment in occupational therapy, the same immediate conditions of purely physical well-being govern as in treatment purely medical. In addition the responsibility for the ultimate attainment of a definite objective is just as great as it is on the part of the doctor.

This means that the first need is for a thorough examination and an enlightened diagnosis and then the prescribing of a definite motivated treatment with a specific

objective in view. This procedure is vital to a properly conceived system of occupational therapy. In inspecting a very great number of hospitals in this country and Canada, the one great lack was found to be in the motivation and objectives, or rather in the lack of both.

In the case of specific functional restoration by means of curative occupations and workshops, the examinations and diagnosis should be conducted by a medical man in close liason with the occupational worker, the medical man deciding the character and duration of the work and the occupational man its form, a definite distinction being made between character and form, with a frequent review from the medical side. Fortunately work of this character has been pretty definitely standardized both in this country and abroad and little that could be said here would add to the excellent books already available.

It is not, however, with specific functional restoration that the occupational worker has most to do. The problem today is particularly with specific economic and its consequent social restoration. The object of all treatments is to place the individual back into the fabric of society a self-supporting, self-respecting unit *as soon as possible*. Economically, socially, and morally, delay is costly, very costly. If we are to escape hospitalization and the host of ills of morale, we must have speed and work motivated to a definite objective. If the one sentence, "We must put the patient quickly in self-supporting work" could be hammered in again and again, occupational therapy would be a hundred times more efficient. A long extended course of treatment may result in physical health and death of morale, this is evident everywhere today. In long continued treatment physical health and health of morale are only possible in most cases by a properly conceived and motivated course of occupational therapy.

Patient Must Desire End in View

Every worker in occupational therapy must understand these generalities and must get this point of view as a background of the technique in any individual case. Occupations must lead somewhere and the patient must want to follow. It is simple and fundamental.

We must examine to find out, to diagnose. A general diagnostician is perhaps one of the hardest men to find, but in every hospital organization the need for one, from the standpoint of occupational therapy, is extremely urgent.

He should, of course, examine all patients under treatment. It is important to have this first examination very thorough and there should be no attempt to save time. It is necessary to get not only the man's occupational history but his social history and in many cases a simple psychological test is of very great benefit. The examiner should have a wide vision and a real sympathetic appreciation of many men and many occupations. After a careful consideration of all the evidence he must determine upon a single definite objective and see that any work given in occupational therapy leads directly or at least in close relation to the objective.

The objective should be discarded only when a better one is conclusively found to exist and the new objective should be followed with all the enthusiasm and singleness of purpose which characterized the pursuit of the first objective. There should be a hesitancy to change, but once changed there should be no hesitancy.

The objective should be definitely understood and appreciated by every occupational worker coming in contact with the patient and the work should be so correlated, directed and motivated that the patient appreciates that a logical and definite attempt is being made by qualified persons to solve some of his real difficulties. Faith in the occupational worker is just as necessary to progress in the case as is faith in the doctor, and faith must rest on a knowledge of work well done, that is on reputation.

The question of proper motivation from a technical standpoint is one of very great difficulty. It presupposes a staff possessing not only technical ability of a high order, but a deep understanding and a wide knowledge of things of the world in general. From a practical standpoint the only way to possess such a staff is through training and the only training worth while is through service, by clinic and by an intensive study of the case records of an individual.

From the experience of the writer the following procedure seems best:

(1) An examination and a full record of the previous history of the case by a qualified examiner whose function it is to record facts.
(2) A review of this examination with the patient on the part of a competent psychologist.
(3) A diagnosis and course of treatment prescribed by an authority, which lead to a definite objective, with a fixed scheme of motivation.
(4) The technical administration of the treatment under close supervision and with a daily record.
(5) A review of all cases at a clinic at frequent intervals, carried through the greater part of the course of training.

The crux of any course of training lies in the objective and motivation. Of these two the motivation is as important as the objective once the latter is established, and is infinitely harder to establish and maintain.

It taxes the resources of the whole staff and in the mind of the writer can be and is much better done by women than by men. The results obtained by some women without training, even in the most difficult cases will always stand out as some of the greatest personal achievements in the reconstruction program of our army hospitals in the recent war.

A STUDY OF SUBNORMAL CHILDREN

About seven months ago a home was established on the grounds of the Jewish Hospital, which is unique in many respects and which is known as the Psychopathic Institute. The primary object of the founders is to make an intensive study of subnormal children, determine the underlying causes, and suggest remedial measures.

Classes in occupational therapy are conducted three afternoons in the week, the children being taught sewing, carpentry, weaving, pottery, and reed work. The object of this is two-fold; it is of benefit to the patient and of great help to those observing the child. The defective and retarded child who has become discouraged through his inability to keep up with the school curriculum, finds to his great surprise, that he is able to cope with concrete tasks and produce definite and constructive results. His self-esteem rises unconsciously and his whole mental attitude is changed. Nothing is more conducive to effort than the knowledge that one has the ability to accomplish or produce. While the children are busily engaged, careful observation often discloses inherent capability or disposition not previously exhibited and which may have an important bearing on vocational training and social adjustment. All these reactions are noted and finely correlated with the facts obtained from the physical and mental examinations, and this comprehensive data helps those in charge not only to make a diagnosis, but also to recommend a course for future action.—*Cincinnati Sanitary Bulletin.*

URGE HOME WORK FOR CRIPPLES

The New York State Society is actively concerned in creating sufficient interest to influence the introduction of an exemption clause, in a bill presented to the last session of the legislature, the purpose of which was to abolish home work in cities of the first and second class throughout the country. The bill failed to pass, but proponents are planning to reintroduce it before the next session. The point is being raised by this Society and various interested groups of individuals that provision must be made in the bill exempting home-bound cripples and the blind, in compliance with the law. The plea is that this helpless group of handicapped be exempt, for the reason that employment with remuneration is what is most needed to keep up the courage and morale; that this group which must work at home, while large enough to be considered, is not sufficiently large to be industrially competitive. The Women's City Club of New York introduced the bill referred to, but the chairman of the committee on tenement home work is very open to conviction concerning the exemption clause.

Pending the above legislation, Mrs. Richard Cook and Miss Lois Deveraux enter upon their duties as visiting instructors to the Home Bound, on January 3. This Society also will begin their activities with instruction for private cases.

WATCH THE POSTURE OF PATIENTS

If we are to see the best results from occupational therapy, we must be careful to avoid unnecessary handicaps, the handicaps of ignorance and carelessness which creep into convalescent progress. Among the most common of our mistakes as teachers is the failure to insist on a healthful and well balanced posture in our pupils.

A bad posture at the loom.

A good posture.

There is no better all around exerciser than the hand loom, no better machine for developing patience, accuracy, and the ability to sustain effort. But if the weaver is allowed to bend over the work, flattening the chest, crowding the abdominal organs down into the pelvis and straining the muscles of the back, he will materially reduce the value of his occupation, bring on early fatigue, and make unnecessarily slow progress.

If, on the other hand, an erect, easy balance is maintained, the work is less tiring, and the patient learns an important lesson in physical hygiene.

Sometimes a bad sitting position is favored by defective vision. The oculists frequently give their patients two sets of glasses, one for distance and one for reading. In some cases, at least, the reading glasses are good only for the regular reading distance, a longer focus may be needed for bench work, music, or such an occupation as weaving. It may be the attempt to get down to a reading glass focus that produces the bent over, flat chested posture illustrated above.

Whenever a patient shows a tendency to bad posture we must have the eyes tested. If they are all right, we are dealing with carelessness and bad habits in the patient and in the aide who fails to correct the fault.

In regulating the diet of consumptive patients, I conceive it to be as necessary to feel the pulse, as it is in determining when and in what quantity to draw blood. Where inflammatory diathesis prevails, a vegetable diet is certainly proper; but where the patient has escaped, or passed this stage of the disease, I believe a vegetable diet alone to be injurious; and am sure a moderate quantity of animal food may be taken with advantage.—Medical Inquiries and Observations (1809) by Benjamin Rush, M.D.

MEETINGS, CONVENTIONS AND CONFERENCES

DIETITIANS ENJOY STRONG PROGRAM

By ANNA E. BOLLER, Riverside, Ill.

THE fourth annual meeting of the American Dietetic Association was held at the Hotel La Salle in Chicago, October 24-27. About 500 persons were registered at the conference.

All during the convention the close relationship between dietetics and medical, nursing and social service became more evident. The three-day program was extensive and included papers and discussions on administrative problems, teaching problems, dietotherapy and social service.

Mary A. Lindsley, manager of the Grace Dodge Hotel for Women in Washington, conducted a most interesting and valuable morning session. The question of equipment was discussed from the point of view of the institution and the housewife. Miss Margaret Proctor of the Y. W. C. A. showed where many mistakes are made in planning kitchens, such as placing sinks too low, tables and cupboards at an incorrect height, and improper arrangements of equipment. She emphasized "humanizing" the home and commercial kitchen. Others on the program were George A. Smith of the Chicago Range Company and Agnes Gleason, manager of the Parkway tea room in Chicago.

The social service section meeting and round table reflected credit on the chairman, Miss Lucy Gillette of the nutrition bureau, Association for Improving the Condition of the Poor, New York City.

Miss Sophonisba Breckenridge, an associate professor of sociology at the University of Chicago, in reply to the question "To what extent should racial customs enter into any Americanization scheme?" said that they should be a part of it "to the greatest extent rendered possible by the knowledge, training, and sympathy of the persons directing the Americanization efforts." More interesting questions are, she said, how this knowledge can be increased and rendered available to a greater number of persons and how the sympathy and tact necessary for the task can be directed towards families that are either foreign-born or not yet adjusted to American life. The American standard of living, she said, is dual: Legislative and voluntary. It is preferable that immigrant housewives should be educated to the latter standard rather than be compelled by law to live up to the former. She urged the social worker, the child welfare expert, and the domestic economist to reach such housewives and to give them instruction in modern housekeeping according to American standards of living.

Mary DeGarmo Bryan, of Jersey City, N. J., was re-elected president of the American Dietetic Association at the fourth annual meeting, in Chicago, Oct. 24-26.

Following Miss Breckenridge's talk four papers were given on "Dietary Customs of Various Nationalities."

At the meeting of the section on education under Dr. Ruth Wheeler, professor of nutrition, University of Iowa Medical College, Iowa City, Iowa, standardized courses for nurses and dietitians were presented.

"What Nurses Need to Know about Dietetics" was the subject of a paper by Miss Helena MacMillan, principal of the school of nurses of the Presbyterian Hospital, Chicago, and a recognized leader in the nursing field. The dietitian, as an educational director, Miss MacMillan declared must feel a great responsibility in helping formulate standards for nursing education. Too much routine work for the nurses must be avoided, she believes, so that more time can be spent with the instructor.

An outline for a student nurses' dietetics course by use of the project method was presented by Miss Katharine Fisher of Columbia University. Student dietitian courses were presented by Miss Octavia Hall of the Peter Bent Brigham Hospital, Boston, and Miss Mary Foley of the Rochester Hospital, Rochester, Minn. Miss Abby Marlatt, University of Wisconsin, gave an outline for two- and four-year preliminary courses for dietitians.

(Continued on page 542)

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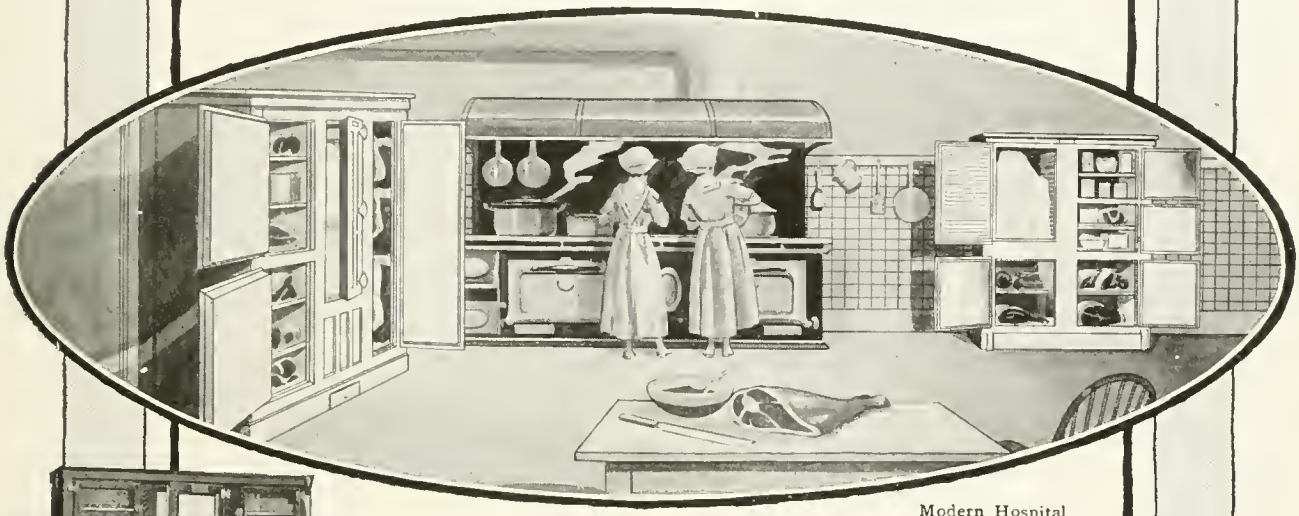

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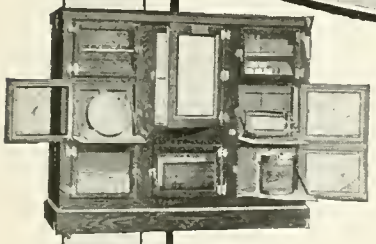

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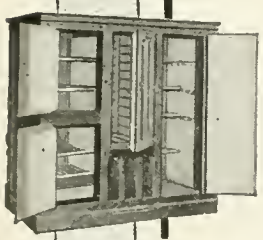

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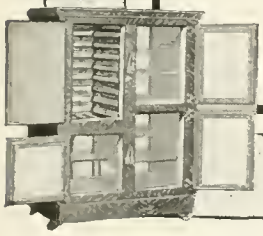

FOR RESIDENCES

FOR DELICATESSEN STORES

Consult the 1920 Year Book for Catalog information.

At the dinner Monday evening, Mrs. Mary De Garmo Bryan, president, outlined the objects of the association, the work that had been done during the year, and plans for the coming year. The convention would do much, she said, toward convincing the public of the fact that the dietitian is a professional person whose training demands utmost care. During the past year the association has been instrumental in installing two courses in dietetics for nurses and a preliminary course for the dietitian in universities, colleges and technical schools. Next year a committee will compile a list of hospitals and classify them according to size, equipment and dietary standards. With this list it will be possible for students to choose hospitals offering the best training.

Diet and Mood

Miss Harriet Vittum of Northwestern University Settlement gave an inspirational talk on "Professional Spirit." Madison E. Bentley, professor of psychology at the University of Illinois, said, in discussing diet and its relation to mood:

"The moods stand closely related to the emotions. Both contain strong feeling and both involve the organism in a diffuse and general way. Anger, joy and fear are typical emotions; petulance, depression and good humor are typical moods. Moods usually last longer than emotions, and they lack the reference to specific events and situations which characterizes the emotions. The mood is a tuning or toning of experience, and it is suffused with pleasantness or unpleasantness.

"Moods are made up in large measure of the same materials that underlie the bodily perceptions of hunger, lassitude, satiety, thirst, appetite, nausea, and the like. These simple materials are pressure, pain, warmth, cold, heat, strain, fatigue, and the simple feelings. In such bodily perceptions as hunger, thirst and satiety, the function is to color and to tone our experiences and to incline us in one direction or another.

"After this analysis of the moods into their simple ingredients, the psychologist proceeds to study their kinds and varieties, and thon to relate the several kinds to their bodily conditions. He finds two varieties, the reflective and the anticipatory moods, which display only a casual relation to the visceral functions, and two other varieties, the quiescent,—gloom, tranquillity, good humor,—and the turbulent moods,—petulance, restlessness, gaiety,—both of which draw largely in their origin upon those organic sensations aroused by the processes of digestion and secretion. The more detailed and accurate description and explanation of these last two classes awaits the cooperative study of the psychologist and the physiologist of nutrition."

Dietitian Not a Diagnostician

Dr. C. P. Howard, professor of internal medicine, University of Iowa, in his paper on "The Sphere of the Dietitian," stated that her sphere is the planning of diets and not diagnosing diseases. In closing he advised, "Shoemaker, stick to your last."

Professor A. J. Carlson of the University of Chicago in his address said that the dislike of certain food is a psychic idiosynerasy with most of us, and that one of the most important tasks of the dietitian is the removal of these imaginary dislikes. This is especially true with children, he believes, and considering the almost universal anemia among them in civilized communities, one may realize that the safety of modern society depends upon training the child to be more omnivorous—that is, to be less finicky about food.

Dr. Sidney Kuh, a leading neurologist of Chicago, read a paper on the "Relationship between Diet and Nervous Conditions—with its Significance in Social Problems." He stated:

"There are no so called nerve-foods, articles of diet that have a specific beneficial effect in functional nervous trouble. Diet is usually determined by the physical condition of the patient. Coffee and tea are harmful if given in any but very moderate quantities,—coffee excites, tea stimulates. There is a difference of opinion as to the cheering effect of alcohol in cases of mental depression. It is on the whole much more harmful than beneficial and with neurotic patients there is the danger of establishing a habit.

Condemns Volsted Act

"The Volstead Act has had a bad effect, since it is prohibition which does not prohibit, as it substitutes for the bad whisky of years ago the worse whisky of home manufacture. It has not materially decreased alcoholism in men, and has led women, who under present conditions have greater difficulty in securing whisky, to an increased use of narcotic drugs.

"Monotonous diet, though it contains ample nutriment, often leads to loss of weight, anemia and tuberculosis. To vary diet as much as possible is necessary in all cases, and the importance of psychic influences in the assimilation of foods is particularly great with the neurotic. Hence appetites are influenced not only by methods of preparing foods, but almost equally by manner of serving it, the presence of congenial company, pleasant conversation, etc. For undernourished neurotic patients, one should use butter freely, both on bread and in the preparing of sauces, soups, vegetables and in the cooking of meats. Fat meats are not desirable; yolk of egg is very valuable. Consider as far as possible likes and dislikes of patients, because then they will take the largest possible quantity of food and assimilate it best. A great deal of harm is done in cases of so-called nervous dyspepsia by too restricted a diet.

"In epilepsy it is not necessary or desirable to eliminate meat altogether; it may be allowed in moderate quantities without harm to patient. A diet containing a very limited quantity of salts is of decided value in this disease. Stomach upsets and sluggish bowels very frequently bring on attacks."

One of the best attended meetings was that of the section on dietotherapy, under the chairmanship of Miss Rena Eckman, University of Michigan Hospital, Ann Arbor, Mich.

Dr. Amy Daniels of the Iowa State Child Welfare Association, University of Iowa, in her talk on "The Dietary Needs of Children," emphasized the importance of a dietitian trained in childrens' dieteties. Children have strange idiosynerasies and these must be corrected to better future generations, she declared.

Prevention of Simple Goitre

Dr. O. P. Kimball of the Medical Department of Cleveland Clinic, Cleveland, Ohio, gave an interesting and valuable discussion on the "Prevention of Simple Goitre," in which he said:

"The practical application of prevention of simple goitre in man was carried out through the public schools of Akron, Ohio, from 1916 to 1920 by Drs. Marine and Kimball of the School of Experimental Medicine, Western Reserve University. Since 1920, it is being carried on as a public health measure by the school authorities. On account of the extraordinary results obtained in Akron,

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it is being carried out as a public health problem by the schools in six Ohio industries where girls are employed. Several school systems of Michigan and Wisconsin are taking it up. Following the work in Akron, it was started in the schools of Zurich, Switzerland, and they obtained such results that it has recently been adopted by the goitre commission of Switzerland to be carried out throughout the whole state as a public health measure."

Dr. R. T. Woodyatt, assistant professor of medicine, University of Chicago, read a paper on "Newer Ideas on the Diet Management of Diabetes and Their Practical Working Out in the Hospitals." He told of the work in the Metabolic Clinic at the Presbyterian Hospital in Chicago.

Mr. John Street of the National Canner's Association talked on "Food Poisoning," in which address he told about an investigation of and an experiment with canned foods.

Mrs. Gertrude Mudge of the nutrition bureau, American Red Cross, read a well organized paper on the necessity to work with the family as a whole. She feels that more work should be done with the child of pre-school age.

Business Session

A business meeting was held Wednesday morning and the following officers were elected for the ensuing year:

Mrs. Mary de Garmo Bryan, president, editor of the Journal of Home Economics.

Helen Pope, first vice-president.

Octavia Hall, second vice-president, dietitian, Peter Bent Brigham Hospital, Boston, Mass.

E. M. Geraghty, secretary, student, University of Illinois.

Ellen Gladwin, treasurer, dietitian, Jefferson Hospital, Philadelphia.

The Chicago Dietetic Association, acting as hostess, planned a series of professional trips for Thursday. About 150 persons stayed over for the day. The three trips were as follows:

1. To hospitals—Presbyterian, Cook County, Michael Reese.

2. To commercial institutions—Sprague, Warner & Co., Marshall Field's tea room, Swift & Co.

3. To welfare centers—Infant Welfare Society, Association of Housekeeping Centers.

After the trips the three groups met for the closing luncheon at the Chicago Beach Hotel, after which a trip through the University of Chicago was scheduled.

The commercial exhibit was large and interesting. Miss Geraghty planned it to cover all lines of special interest to the members in the various fields. The exhibit included such things as: Well known beverages served in new ways, package meats, suggestions for utilizing less expensive cuts of meat, two types of dishwashing machines, heavy duty electrical equipment, two types of electric toasters, an excellent bread slicer, a mixing machine, fancy groceries, staple canned goods, two cleaning powders, and a food cart.

The non-commercial exhibit, as planned by Mrs. J. W. Martin, Miller Hospital, St. Paul, contained many valuable charts, posters, etc.

TO CORRECT AN ERROR

Through an inadvertence in the November issue of THE MODERN HOSPITAL, the reproduction on the cover of the Good Samaritan Hospital of Cincinnati was labeled St. Elizabeth's Hospital of Cincinnati. The management hastens to correct the error.

HOSPITAL ORGANIZATION IN NEW ZEALAND

New Zealand hospitals may boast of some advantages over their sister institutions in America. Among them is their privilege to levy for their needs upon municipalities and counties, such levies carrying government subsidy. Hospitals of the commonwealth are administered by boards consisting of representatives of contributory local authorities.

The New Zealand Division of Hospitals under the Department of Public Health, Hospitals and Charitable Aid possesses full inspectorial powers. The department under which the Division of Hospitals comes has two technical inspectors, who closely examine all plans for buildings before the Minister is recommended to give his consent to their construction. No capital expenditure of more than 250 pounds can be undertaken without the precedent consent of the Minister.

The Department has a supplies bureau which undertakes the purchase of supplies for hospital boards which wish to avail themselves of this service. The services of the Department's inspecting accountant and consulting engineer may always be obtained by hospital boards. A system of hospital accounts uniform in regard to form, is in use but no attempt has yet been made to insist that a uniform set of books be kept by each institution.

Lethargic hospital administrators, under the New Zealand system, it is said, are inclined to lean on the government department in many instances rather than use their own energy and initiative. Two years ago the department called a conference of hospital boards and some of the secretaries met together with the object of forming a Hospital Officers' Association. Nothing has come of this matter. It is likely that if the New Zealand hospitals were independent voluntary bodies without the government to depend upon for finances, a hospital association of some nature would have been formed long ago.

Those New Zealanders who urge the formation of a hospital association believe that the Department of Public Health, Hospitals and Charitable Aid is of more benefit as a bureau of inspection and administration, while a hospital association would be productive of valuable discussion and the circulation of literature on subjects of importance and interest regarding hospitals.

PENNSYLVANIA HOSPITALS TO ORGANIZE

The Hospital Association of Pennsylvania expects to effect a permanent organization on December 7 when a meeting will be held at the Penn-Harris Hotel in Harrisburg. The morning session will be of a business nature, with the adoption of a constitution and by-laws, the election of officers and the appointment of committees as the chief issues.

The afternoon session will consist of lectures and round table discussion with Dr. Edward Martin, state commissioner of health, and Dr. John M. Baldy, commissioner of the new welfare department of Pennsylvania, as speakers. Mr. H. E. Bishop, superintendent of the Robert Packer Hospital at Sayre, will preside.

Arrangements for the meeting are being made by a committee composed of Mr. Daniel D. Test of Pennsylvania Hospital at Philadelphia, Mr. Bishop, and Miss Victoria E. Armstrong, superintendent of the Citizens' General Hospital, at New Kensington. Mr. G. Walter Zulaud, superintendent of the Allegheny General Hospital, is chairman of the committee to prepare and submit for adoption a constitution and by-laws. The temporary chairman will be Mr. John H. Smith of the Hahnemann Hospital at Philadelphia.

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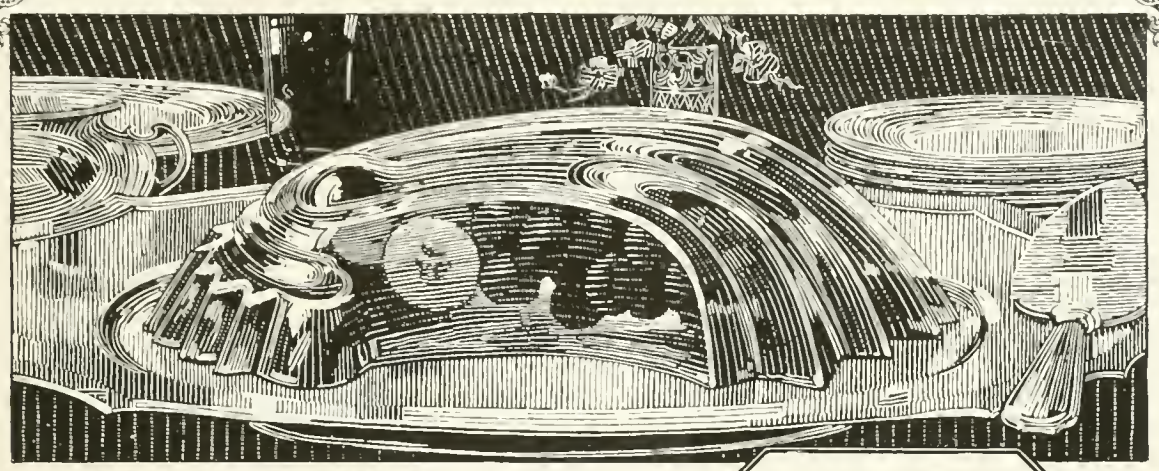

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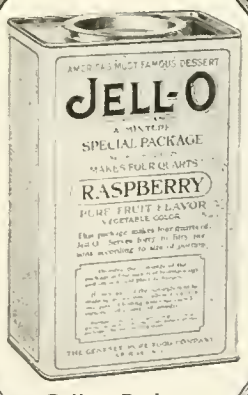

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HOSPITAL STANDARDIZATION IS THEME OF DAY AT COLLEGE OF SURGEONS' CONGRESS

ASPECTS of hospital standardization were treated in eight interesting papers read before the Clinical Congress of the American College of Surgeons during its recent session at Philadelphia. An entire day's program, October 24, was given over to papers and to round table discussions of hospital standardization.

The round table conference conducted by Dr. Malcolm T. MacEachern, superintendent of the Vancouver General Hospital in British Columbia, had to do with staff organization, medical records, laboratories, nursing and general problems. As a central theme of the discussion was taken hospital standardization in its relation to the improvement of the professional work of the hospital and better service to the patient. Some valuable material developed in the discussion, which took the question and answer form, replies being made by some of the most experienced hospital executives, surgeons and nurses in the United States and Canada.

John B. Deaver, M.D., of Philadelphia, president of the American College of Surgeons.

At the morning session Dr. George E. Armstrong of Montreal, president of the American College of Surgeons, presided.

Dr. Franklin H. Martin, secretary-general of the college, discussed at the morning session the development of its hospital standardization program during the past five years. The original purpose, according to Dr. Martin, was the betterment of surgery by establishing certain high standards for those who are admitted to fellowship in the college. To ascertain the status of applicants for fellowship, it was necessary to standardize and improve case records. The standards formulated in Washington for the use of army hospitals also had a close bearing on the standardization program of the college, he declared. Dr. Martin then brought out the progress made by the standardization campaign from 1918, when eighty nine hospitals met the standard, until this year, when 74 per cent meet the standard. The improvement of surgery was said to be inseparably linked with hospital betterment.

Dr. Robert L. Dickinson of New York spoke on "Hospital Standardization from the Viewpoint of the Medical Profession." He made a plea for a more analytical staff review, in which results are carefully scrutinized. The importance of follow-up systems was emphasized, as well as the need for more accurate statistics regarding the mortality rate and percentage of infections of various diseases and operative procedures.

A report on the hospital survey work of the college in 1921, by Dr. Frederick W. Slobe of the hospital standardization department, showed a total of 1,017 hospitals visited. Of the 761 general hospitals in the United States and Canada, having 100 or more beds capacity, 568, or 74 per cent, are on the approved list. Only 18 per cent of the approved hospitals are listed with an asterisk this year, as compared with 47 per cent as listed last year, showing a relative decrease of the use of the asterisk. Dr. Slobe also stated that it is the hope of the college to revisit all of the smaller hospitals next year, so that they may be included in the list of approved institutions.

Dr. A. K. Haywood, superintendent of the Montreal General Hospital, in Quebec, spoke on "Hospital Standardization from the Viewpoint of the Hospital Superintendent." Dr. Haywood declared that hospital standardization is synonymous with hospital betterment. In addition to having clinical staff meetings, he emphasized the need for regular conferences of all those associated with the business administration of the hospital. The importance of autopsies was stressed also, Dr. Haywood stating that 85 per cent of autopsies were obtained in the Montreal General Hospital during 1920.

Dr. Newton E. Davis, executive secretary of the conference board of hospitals and homes of the Methodist Church, spoke on "The Viewpoint of the Hospital Trustees." There is a need, he said, of educating board members to take more interest in the clinical aspect of the hospital. The program of the College, according to Dr. Davis, should appeal to business men as it gives them an accurate index to the results in the hospital. Dr. Davis is conducting a survey of sixty-five Methodist hospitals, the support of which he pledges to the program of the College .

Dr. John Baldy of Philadelphia, in his paper dwelt upon the relationship of hospital standardization to laboratory service, stating that monthly laboratory reports to the board of trustees furnish them with reliable information concerning the medical staff. In this way the amount of laboratory tests asked for by each physician can readily be ascertained. Physicians, that use the laboratory most frequently, are more careful in their case records and diagnosis, he says, because the laboratory checks. Further, pathologists should act as consultants to the staff members, and, as such, he believes, be allowed liberties in the wards.

Rev. Fr. Charles B Moulinier, S.J., president of the Catholic Hospital Association, stated that from a scientific viewpoint the analysis of assembled facts is the keynote of the hospital standardization program of the college. This, said he, is the era of group thinking. A sincere and frank cooperation between the staff members, a fearless search for the truth and a frank admission of mistakes constitute the bases for the improvement of the whole profession. Real analysis of results at staff meetings will automatically insure complete records and adequate laboratory work. "Hospital standardization," Father Moulinier declared, "means the standardization of the medical profession in mind, character, and heart."

Adv. page 46

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In his paper, Dr. D. Z. Dunott, chairman of the medical and surgical section of the American Railway Association, stated that 1,700,000 men were injured by railroads in the past ten years, 100,000 of these being killed. His committee has endorsed the minimum standard of the College and recommends that railroads employees, except in emergencies, be treated in hospitals meeting the minimum standard.

Favors Industrial Field

Dr. Edward Martin, commissioner of health of the State of Pennsylvania, declared in his address that the problems of industrial hospitals are those of civil life and that industrial medicine and surgery are deserving of the best minds in the medical profession. Doctor Martin deprecated, in general, the system of full-time men in industrial work.

In the discussion of Doctor Martin's paper by Dr. W. O. Sherman, chief surgeon of the Carnegie Steel Company, Pittsburgh, it was stated that 125,000 accidental deaths occurred annually and that thirty-three per cent of compensation cases require consultation of further treatment from various specialists. A plea was made for the standardization of various forms of surgical treatment and the need for greater use and equipment for electro-, physio- or hydro-therapeutic departments.

Dr. John B. Lowman of Johnstown, Pa., dwelt upon the need of more adequate supervision in the dispensaries of industrial institutions. Dr. M M. Seymour, commissioner of health of Saskatchewan, Canada, told the Congress that in Saskatchewan, with a population of 850,000, the public is being educated as to the necessity of hospitals. According to the law in Saskatchewan, hospitals are built by taxation. Their provincial hospital association has officially adopted the minimum standard of the College.

Dr. Malcolm T. MacEachern, superintendent of the Vancouver General Hospital of Vancouver, British Columbia, in a general summary of hospital standardization, said statistics show that hospital standardization has lowered the death rate, has decreased the number of operations, infections and complications, and has lessened the duration of the patients' stay in the hospital. Hospitals have developed a new sense of responsibility to the community, he declared. Boards of directors are now being furnished with monthly reports, which give a medical audit as well as a financial audit. People are asking which hospitals in a community are standardized. Municipal authorities in certain instances have based their grants of money upon the development of standardization in the hospitals. Hospital standardization results in a direct economic gain to the community.

ROUND TABLE CONFERENCE

The following answers to important questions placed before the Congress at the various sections of its round table conference were given by surgeons of note:

Staff Organization

Q. Many hospitals find difficulty in formulating staff by-laws, rules and regulations for the guidance of the professional work therein. How can the College give them greater assistance? Can they secure a set of standard by-laws, rules and regulations setting forth the principles involved which shall guide them in drafting their own?

A. (By Dr. Frederick W. Slobe, on the staff of the American College of Surgeons). Sample staff by-laws, rules and regulations can be obtained by writing the American College of Surgeons headquarters at 40 East Erie Street, Chicago. In this office there are samples from numerous hospitals throughout the United States and Canada and from these can be built by-laws, rules and regulations to meet the special needs of any hospital. Several samples are available for distribution at this meeting. The College will be glad to supply any one with this information.

Q. Many hospitals require the attending doctors to sign a pledge or card, the latter often being known as the "Physician's Registration Card." Has this been found beneficial? What is the best form to use?

A. (By Dr. Slobe). In some communities where fee-splitting is practiced more or less widely, it is found advisable to sign a pledge or card prohibiting same, but, generally speaking, it is more desirable that each member of the staff of the hospital should subscribe his name to the by-laws, rules and regulations as drafted. These by-laws, rules and regulations should contain all the essential principles of hospital standardization.

Q. In certain instances the attending doctors of hospitals have been found lacking in clinical interest. What can be done to stimulate more interest in such cases?

A. (By Dr. Frank D. Jennings, of Brooklyn, New York.) The staff conference as recommended in the program of hospital standardization has been found the greatest stimulus to clinical interest amongst the professional group attending the hospital. These conferences should be arranged at regular intervals and with definite and interesting agenda. They will result in better acquaintance, better cooperation and more increased clinical interest.

Q. How often should the staff conference be held and what is the best form for it to take, a luncheon, a dinner or an evening meeting? What should constitute the agenda for such a meeting?

A. (By Dr. Jennings.) The staff conference in hospitals takes various forms; in some a luncheon, others a dinner, or others an evening meeting. So far as known, very successful meetings have been held with or without luncheon or dinner, and it is not considered that this latter feature of something to eat influences the meeting much. An evening meeting will afford more time for discussion of the work of the hospital. The agenda for such a meeting should be, first, a review of the professional work of the hospital during the month, especially mentioning anything of clinical interest, or of such work as did not measure up to the best results or such results as are desirable. Secondly, the detailed consideration of the following, all matter of which to be presented by the doctor in charge of the patients:

(a) Deaths during the period.

(b) Patients discharged unimproved.

(c) Infections and complications occurring in the hospital.

Thirdly, recommendations for the betterment of the professional work of the hospital.

Q. What is the best way to stimulate more consultations between members of the staff in hospitals?

A. (By John M. Smith, Superintendent, Hahnemann Hospital, Philadelphia.) Consultations between members of the hospital staff are best stimulated through staff conferences, which bring the doctors together better in the discussion of their work, collectively or otherwise.

Medical Records

Q. Should not every medical man be responsible for seeing that a complete history is provided for each one of his cases, whether public or private?

A. Yes. Every medical man should be responsible to see that a complete history is provided for each of his cases, whether private or public.

Q. What is the best way to secure operating room records and what should they consist of mainly?

A. (By Simon Tannenbaum, Superintendent, Jewish Hospital, Philadelphia.) Operating room records are secured in various ways. Firstly, the dictation to a competent record clerk or stenographer, preferably a nurse, if same can be secured. Secondly, by using a dictophone. Thirdly, by the surgeon or assistant writing same. The most effective method is for the surgeon to dictate the report immediately to a capable stenographer or record clerk.

Q. What is the best procedure to keep accurate records of all infections occurring post-operative?

A. (By Dr. Charles Norris, Woman's Hospital, New York City.) Some hospitals have a wound record sheet, a sample of which was shown to the conference. This wound sheet gives an accurate description and daily diary of the wound throughout. The diary on any case report should contain accurate information as to the condition of the wound and especially as to infection. The intern on service, in making his daily notes, should put this down and report the same to the senior attending surgeon on duty. He should have some simple method of collecting such data.

Q. Who should be responsible for overseeing of the medical records as to completeness and quality?

A. (By Dr. F. L. Adair, Swedish Hospital, Minneapolis.) Responsibility of overseeing the medical records as to completeness and quality should be assumed by the hospital authorities and the doctor in charge of the patient to whom the record refers. If possible, a capable medical visitor in charge of the records would be the most satisfactory, in order that he may make sure that all the data is complete and

Adv. page 48

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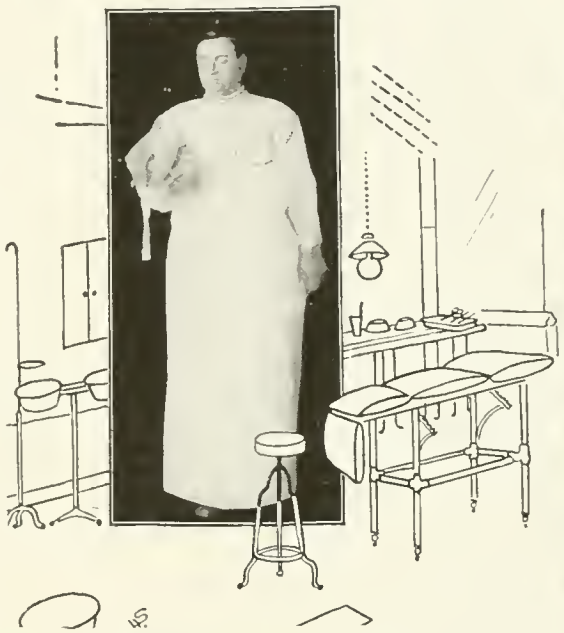

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correct and he can keep close in touch with the doctor in charge of the case. Some hospitals request the attending doctor to sign the record when complete.

Laboratories

Q. What laboratory work should a hospital of 75-100 beds provide as a minimum service?

A. (By Dr. Malcolm T. MacEachern, Superintendent, Vancouver General Hospital, British Columbia.) The answer to this question was given in a pamphlet containing a reprint of a paper given by Dr. G. F. Strong, assistant superintendent of the Vancouver General Hospital, at the British Columbia Hospital Association, and the information of this pamphlet can be obtained through the hospital library and service bureau at 22 East Ontario Street, Chicago. Several hundred copies were distributed at this conference. This pamphlet shows the minimum and essential laboratory service necessary for every hospital and supplies the basis upon which a maximum service can be built up.

Q. A hospital wants a routine pathological service in connection with its surgery. How can such service be financed?

A. (By Dr. S. C. Davidson, Superintendent Rockford Hospital, Rockford, Ill.) The financing of a routine pathological service in connection with the surgical is best done by a flat charge, either on a daily ward charge or by an addition to the operating room fee. Though this charge applies to every patient, whether using the service or not, it seems that by virtue of such a service, the patient will be receiving all around better and more efficient care in the institution.

Q. How many hospitals are routinely putting through all the material removed in the operating room and thus checking up diagnoses?

A. (By Dr. Davidson.) A large number of hospitals are found today putting through all the material removed in the operating room and checking up diagnoses thereby. In this connection it was heartily recommended that the routine pathological laboratory service should be attached closely to the operating room department, so that the pathologist and the surgeon are close together for consultation either before or after the removal of the tumor or specimen.

Q. How can the pathologist arouse more interest in clinicians and interns along laboratory lines?

A. (By Dr. A. K. Haywood, Superintendent, Montreal General Hospital, Quebec.) The pathologist can arouse more interest in the clinicians and interns along the laboratory lines by holding regular pathological conferences at which a demonstration is made of all the specimens and tissues removed during the period since the former conference. It was also suggested that in any case for post-mortem, the intern or doctor in charge of the service should list the diagnoses before the autopsy commences and further, that due announcement be made of all autopsies so that as many men as possible could attend.

Nursing

Q. Can a hospital attain the minimum standard with what is considered an incompetent nursing staff?

A. (By Dr. Charles Mayo, Rochester, Minn.) It is the general consensus of opinion that the minimum standard can not be attained in hospitals where there is an incompetent nursing staff.

Q. Can a hospital attain the minimum standard with what is considered an incompetent nursing staff?

A. (By Miss S. Lillian Clayton, Director of Nurses, Bureau of Hospital, Department of Health, Philadelphia.) Yes.

Q. Nurses' records on patients in many instances are useless. What are the essentials of such records, and how can they be made of greater use?

A. (By Miss Katherine Tucker, Superintendent Visiting Nurse Society, Philadelphia.) The essentials of nurses' notes in connection with the records assigned to this group, should be the intelligent expression of accurate observations made on the patient at frequent intervals. These observations should be more of a positive nature than negative. Particular attention should be given to describing accurately of each specimen or tissue in such manner that a full and comprehensive knowledge of the same may be obtained by the doctor when he visits the patient. In short, nurses' notes should be complete, accurate and expressed in an intelligent manner and in good style.

Q. What constitutes competent and sound applied nursing service in our hospitals today?

A. (By Miss Mary M. Riddle, Superintendent Newton Hospital, Newton Lower Falls, Mass.) Competent and sound applied nursing service today presupposes primarily a nurse with good education and mental development. On her admission to training she should have thorough instruction theoretically and practically, with close supervision over all her work. She should learn how thoroughly to do the various practical procedures in the class or demonstration room before attending the patient. The kind of service which she will render will depend a good deal on the fundamental training she is securing. Coupled with diligence in her duty that causes her to attend promptly and efficiently to all the patients' needs, so far as she is able, whether these are large or small, social or scientific, keeping in mind at all times the best general welfare of her patient. Sound and competent nursing service to the patient means an intelligent carrying out of all routine nursing orders, of all doctors' orders for medication and treatment and particularly of anticipating the patients' needs ever by prompt attention to same.

General

Q. A hospital of 100 beds with limited funds, desires to have records and to do at least the essential x-ray and laboratory work, but cannot secure interns or afford to engage a radiographer or pathologist. How can these services be taken care of under such circumstances?

A. (By Dr. MacEachern.) This question may be answered by reference to the pamphlet referred to in question No. 1 on laboratories. Some large hospitals, and especially the Vancouver General Hospital of Vancouver, British Coumbia, have established a ten months' course for graduate nurses to acquire technical skill in case recording, x-ray and laboratory work. The graduate nurse spends two months in the records department, acquiring the knowledge necessary in the handling of records; four months in the x-ray department for routine purposes; and her final four months in the laboratory, acquiring technical skill in doing the routine laboratory work necessary in hospitals. By thia triple course, she is able to carry on this technical work, which is so essential in every institution. It presupposes, however, the cooperation of the medical men attending and team work between the large and small hospital laboratories.

Q. Should operative cases, other than emergency, be in the hospital for a period before operation? What routine preanesthesia examination and laboratory work should be done on each case?

A. (By Dr. MacEachern.) Operative cases should be in the hospital at least ten to twenty-four hours before operation. Indeed, there are several types of cases which should be in longer for careful observation and more intricate examination previous to operation. Every case, except of an emergency type, should have a history completely written up before operation. Special examination should be made before the anesthesia is given to determine the patient's condition to stand same, as well as to determine the kind of anesthesia best to use. In every case routine urinalysis should be done before operation and in children nose and throat swabs taken to eliminate diphtheria carriers.

Q. How can the Board of Trustees be impressed more thoroughly with the crucial importance of the patient rather than the financial aspect of the hospital?

A. (By Dr. MacEachern.) The Board of Trustees at the hospital can be influenced to take more interest in the professional work of the hospital if they are supplied with a monthly report of the same. Some hospital superintendents provide the Board of Trustees with a report somewhat as follows: Firstly, the amount of work done during the month; secondly, the physical assets of the institution, patients discharged well, patients discharged improved; thirdly, the physical liabilities, deaths during the month, infections during the month, discharged unimproved during the month; fourthly, the number of consultations held, this to include laboratory tests, x-ray examinations, etc.

Q. Have hospitals found fewer operations, less incompetent and irregular surgery, and fewer deaths, since hospital standardization has been developed and promoted?

A. Investigations made (a) on specific professional cases; (b) on hospital service, whether administrative or scientific. From such a monthly report the board can have a proper balance sheet, formulated in their minds for considering the physical report as against the financial report of the institution. Hospitals which have adopted the minimum requirements are unanimous in stating that there is less incompetent and irregular surgery done and that there are fewer patients since hospital standardization has been begun. This is due to better diagnosis, better working out of cases and proper investigation of results by staff conferences and other meetings. Two prominent hospitals have submitted interesting statistics on this matter. Both of these institutions give a comparison before and after hospital standardization and on the same basis, the number and type of cases.

In hospital No. 1, before standardization the percentage of patients operated upon is 57 and 65 per cent, but since standardization has been reduced to 40 and 47 per cent. The death rate in the same institution before standardization, exclusive of influenza and tuberculosis, was between 41 to 46 per cent per thousand and since standardization ranges between 23 and 28 per cent per thousand. Hospital No. 2, before standardization, shows that 44 per cent of the patients underwent operation, and since standardization, 30.5 per cent. The death rate before standardization was 35 per cent per thousand and has been reduced to 24 per cent per thousand. It is interesting to note two operations that were performed during this period. The number of curettages before standardization were 4.2 per cent and since standardization have been reduced to 2.7 per cent. Likewise, the number of appendectomies before standardization were 12.3 per cent and since standardization have been reduced to 7.6 per cent. Another interesting fact which some hospitals claim is that with improved efficiency in the scientific side of the hospital, the patient's days stay has been

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reduced considerably. Hospital No. 2 before standardization shows that 15.1 per cent was the average days' stay per patient, but since standardization has been reduced to 13.8 per cent.

Q. What is the best follow-up system for patients discharged from the hospital to ascertain whether the hospital is functioning efficiently in every respect?

A. Hospitals find several follow-up systems successful. Most of the follow-up work done in hospitals is done through the social service departments. By appointment, patients discharged from the institution are re-called on a certain date for further examination by the chief of the service, or one of the assistants. A careful follow-up record is made. When no response is secured from correspondence, personal visits by the social service nurse often brings the patient. Probably there is no better way than this, or to have some officer obligated to arrange for the return of cases discharged at stated periods for further examination, all of which to be carefully recorded by the hospital with the other records of the patients and thus carry on a thoroughly well organized follow-up system.

REGINA IS HOST TO THREE HOSPITAL ASSOCIATIONS OF WESTERN CANADA

THE Western Canada Hospital Association is made up of hospitals from the four western provinces of Canada, namely,—Manitoba, Saskatchewan, Alberta and British Columbia. Representatives from each province meet annually in one or other of the provinces in turn, during the same week as the local or provincial hospital association meets. This year the conference was held in Regina, on the two days preceding the Saskatchewan Hospital Association and Western Canada Catholic Hospital Association conventions. The programs of the three conventions covered four days and evenings, making a real hospital week for Regina and the province.

The Western Canada association was organized primarily to advance hospital standardization or betterment of service, and also, as far as possible, to coordinate hospital policies and activities in the four rapidly growing and developing provinces where the question of the care of the sick is regarded with great interest and importance.

The president of this association since its beginning has been Dr. M. M. Seymour, commissioner of public health for the Province of Saskatchewan, who has been chiefly instrumental in the introduction and development of the municipal hospital system in Saskatchewan.

The program was made up of able addresses by Dr. A. K. Haywood, superintendent of the Montreal General Hospital; Dr. George Stephens, superintendent of the Winnipeg General Hospital; and Dr. M. T. MacEachern, superintendent of the Vancouver General Hospital, as well as many other authorities on all phases of hospital work.

Delegates Widely Entertained

The delegates were entertained during the convention by many persons and organizations in Regina, including Lieut.-Gov. Newlands and Miss Newlands, the provincial government, the municipal council, the medical association, the hospitals and others, at receptions, luncheons and motor drives. Throughout the entire meetings a splendid spirit prevailed.

Possibly the most interesting session was the public meeting held Tuesday evening, November 1, at which the two main speakers were Dr. M. T. MacEachern of Vancouver and Dr. A. K. Haywood of Montreal, the former speaking on hospital standardization and its effects on service to the patient, and the latter on the responsibility of the community to the hospital. Both these addresses held the interest and close attention of the audience for more than two hours.

Dr. MacEachern gave in detail a complete history of the movement of standardization and its influence on hospital service through more efficient and accurate diagnosis. He brought out that the better working out of cases, better diagnoses and more intelligently applied treatment combined with thorough check-up and review analysis of the hospital work, would result in: Lower death rate in hospitals; reduced number of operations; fewer post-operative infections and complications, and lessened days' stay of patients in hospital. He indicated how this movement is being accepted with satisfaction by all groups interested or connected with hospital work, including the administrative staff, attending medical staff, board of trustees and others, and that governmental and municipal bodies are now becoming interested in the institutions that comply with these requirements. He ended his address by an appeal to all the citizens to take an intelligent and enthusiastic interest in the work carried on by the movement.

The Hospital As An Educator

Dr. Haywood, in his address on the community's responsibility to the hospital, reviewed in an interesting manner the difficulties experienced by the Montreal General Hospital in securing sufficient finances to carry on the work. In recent years drastic measures have had to be taken in order to arouse the community's recognition of its responsibilty to support this admirable work, he declared. The speaker emphasized the need of means of hospital support other than that of philanthropy and

Delegates to the Western Canada Hospital Association

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is invaluable as an aid in speeding the recovery of patients. Use it generously.

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We particularly recommend Kellogg's Bran for bedridden cases. It can be used to the greatest advantage.

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¼ cup sugar; shortening size of an egg. Cream shortening and sugar together. Add to this—1 egg, 1 cup sour milk (or sweet milk), 1 cup Kellogg's Bran, 1¼ cups flour, 1 level teaspoon soda (or two teaspoons of baking powder if sweet milk is used), pinch of salt. Mix well. This will make one dozen muffins.

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endowments, both of which are becoming exhausted and inadequate to meet the demands of the time. One of the most urgent responsibilities of the community towards the hospital at present is to recognize its need of more financial support from all classes, he stated.

Dr. George Stephens of Winnipeg gave a very interesting address on the hospital's responsibility to the community. The hospital's first function, he said, is to care for the sick and bring them back to health in the quickest, most competent and comfortable manner. The second function is that of teaching doctors, nurses, the patients and the public. The hospital's function as a teacher and educator of the community may be more or less incipient and not recognized, he declared, but is a great factor in public health propaganda. Its third function is to afford research in medical science, he believes.

May Learn from the Military

Lieut.-Col. H. F. Munroe of Saskatoon, a man with extensive experience in military hospital administration, in an address referred to several features of military hospital administration which may be applied with advantage to civil institutions. He stressed as a most important point a clear definition of authority, duties and responsibilities. There should be organization from above down, he believes, so that responsibility can always be placed.

Dr. M. R. Bow, superintendent of the Regina General Hospital, spoke on the coordination of hospital service to produce efficiency. It is to the benefit of superintendent and staff to get together in round table conference regularly to discuss the affairs of the institution, he brought out. Dr. J. G. A. Scroggy of Kerrobert, Sask., outlined a plan for the administration of a small hospital, calling attention to the importance and real value to the community of a small institution. In the administration of the small hospital several services must be combined and grouped under individuals, he declared, which later, as the institution grows, can be segregated. Small hospitals in Saskatchewan are developing along standard lines and are filling a most useful function in their respective communities, Dr. Scroggy declared.

Another well prepared paper was that by Dr. W. A. Dakin, former superintendent of the Regina General Hospital, on "The Hospital and the Press." The press is of great value to the hospital in giving publicity to its work and in educating the public to its true perspective, he declared. He pointed out the need of always being frank and open with the press, and of giving to the newspapers all the information that is possible and ethical to release. The press can be a cooperative institution of great value to any hospital and in turn do the community good by education which it can disseminate, said Dr. Dakin.

Dr. R. G. Ferguson, superintendent of the Saskatchewan Sanitarium, Fort Qu'Appelle, comprehensively set forth in his paper the importance of good morale in the hospital staff. This can only be established by good organization, good living conditions, and good treatment, he asserted. By giving the staff information about the institution, by holding round table conferences, by establishing through several means a spirit of personal pride in their hospital, morale can be greatly advanced.

The keynote of the entire convention was the desire on the part of all for betterment of service to the patient and for obtaining increased hospital interest from all groups. The week will undoubtedly be one of the greatest means of stimulating hospital interest in Regina and Saskatchewan.

At the close of the convention a business meeting was held and the usual routine carried out. Dr. George Stephens, superintendent of Winnipeg General Hospital, was selected as the next president, and Dr. Warren A. Panton of Regina, secretary. The meeting of 1922 will be held in Winnipeg.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION IS NEW NAME

The Baltimore convention of the American Occupational Therapy Association in October was a great success. There were some 220 registered, and the members hailed from many states. Naturally, those from the south and the districts about Baltimore, were most numerous. Active working aides were, as usual, in the majority, but this year saw more doctors present than ever before.

Perhaps the most important business transacted was that connected with the new constitution, which was adopted with very few dissenting votes. Members of the old board of managers, who drafted the numerous amendments, believe that the business of the association will be expedited and that there will be at the same time a much more representative government. The actual conduct of business is now in the hands of two persons, who with the president are answerable to the new House of Delegates, which this year has twenty-two members elected from eight state societies.

The change of name from the cumbersome National Society for the Promotion of Occupational Therapy to the crisper and quite as descriptive American Occupational Therapy Association is certainly an improvement. A.O.-T.A., then, are our own official letters for the present, and probably for always.

The meeting at the Phipps Psychiatric Clinic was the high point of the convention with stirring addresses by Dr. Adolph Myers, Mrs. Eleanor Clarke Slagle and Mr. Louis J. Haas. The afternoon meeting at the Sheppard and Enoch Pratt Hospital at Towson deserves special mention. Members were taken out to Towson in Public Health Service motors, and a delicious out of door luncheon was served by the hospital in advance of the round table conference which occupied the rest of the day. Two dances and a vaudeville show gave more than usual gaiety to the meeting. This feature, or something like it, will doubtless be carried out again, as most of our members are young and ready to enjoy the social opportunities as well as the more serious business of the conventions. The exhibition of crafts work was exceptionally good and included this year a showing of models worked out and recommended by the aides themselves or by professional designers and craftsmen. There was also a commercial exhibit showing all sorts of material and equipment for occupational therapy.

Too much credit cannot be given to Dr. W. B. Dunton and his assistants, who were responsible for the excellent arrangements at the Southern Hotel and elsewhere.

The officers and committees elected were as follows:—

President, Dr. Herbert J. Hall; vice-president, Dr. G. Canby Robinson; secretary-treasurer, Mrs. Eleanor Clarke Slagle.

Board of Management: Mrs. Cornelius J. Sullivan and Mrs. Carl Henry Davis.

In some small hospitals, even yet, the superintendent is expected to do everything from the managing of the hospital and the training school to the stoking of fires in winter if the fireman fails to appear.

Adv. page 54

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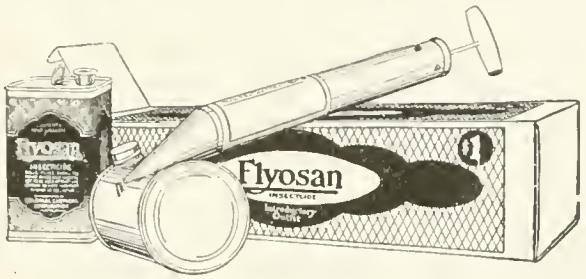

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THE DEVELOPMENT OF THE DENTAL CLINIC IN HOSPITALS AND DISPENSARIES

BY MICHAEL M. DAVIS, JR., PH.D., NEW YORK

DENTAL clinics have been developed of four types:

1. In connection with industrial or commercial establishments.
2. In connection with hospitals and dispensaries.
3. As public health clinics:
   a. In public schools.
   b. Independent local clinics.
   c. Dental institutions founded as part of a community dental program.
4. In connection with hospitals and dispensaries.

Only a brief mention in this article can be made of types 1, 2, and 3.

1. *The dental infirmary* (of the dental college) has had a limited range of community service. The demands of dental practice have been largely for curative work, and the service of the dental infirmary connected with the dental college had been primarily to give the student opportunities for practice in various forms of curative work, chiefly in adults.

Industrial Dental Clinics

2. *Industrial plants,* coming to a realization of the importance of sound teeth to health and efficiency, have in many instances installed a dental clinic. Some seventy-two plants in the United States are known to have taken this step. Sometimes the expense is borne entirely by the firm, and sometimes the employees pay for the cost of materials. Some firms offer only emergency treatment, and send the employee to private dentists for further care; other require the employee to have his teeth put in order and offer him the service of the clinic. The firms that have installed dental service are invariably enthusiastic about its benefits both to the health and to the self-respect of the employees.

Dental Work in Schools

3. *Public Health Dental Clinics.* The dental clinic established primarily for the purpose of meeting community dental needs is a very recent development. These public health dental clinics are not merely those which have been established in public schools or in special dental institutions particularly for preventive work and for children; the public interest has also led to the establishment of many dental clinics in general dispensaries and under independent auspices. The public health movement has taken hold of the dental clinic because of recognition that adequate dental care for the community cannot be furnished as an adjunct to private dental practice, and is in large measure a public project which must be handled by public and semi-public agencies.

Dental clinics in the public schools have been developed considerably in the United States and in some European countries, but are as yet in their infancy compared with the need. A number of social settlements and philanthropic organizations, feeling acutely the need of their clients for dental service, have established small clinics in neighborhood houses or health centers. Large institutions have been especially established as public health measures in Rochester (The Rochester Dental Dispensary), and in Boston (The Forsyth Dental Infirmary).

4. *Dental Service in Hospitals and Dispensaries.* The growing recognition of the connection between dentistry and medicine has been manifested in many ways, among them the increase in dental service in general hospitals and dispensaries. Dental work or dental diagnosis in the general hospital was practically unknown a few years ago.

Inquiries were sent during the course of this survey to 282 general hospitals, including almost all those in the United States of 100 beds or over. One hundred and forty-four replies, or 51 per cent, were received, a rather high average of replies to questionnaires of this sort.

The following questions were asked:

1. Do you have a dental service in connection with your hospital?

2. If so, is this a dental service with rank as a hospital department and ward beds assigned, or is it merely diagnostic in character?

3. Is there also a dental clinic in your out-patient department, in which treatments are given, and if so, what is the size and scope of such clinic?

4. Do you feel the need of a dental service, either therapeutic or diagnostic, in your hospital or your out-patient department, if you have not already developed it and what policy do you think a hospital should pursue in this matter?

Eighty-nine of the 144 replies reported dental services

*This is a portion of a report on dental needs and dental facilities in a number of selected cities and medical institutions throughout the country, prepared by the Service Bureau on Dispensary and Community Relations of Hospitals of the American Hospital Association, at the request of Mr. Julius Rosenwald of Chicago. The complete report will shortly be published in book form.

Adv. page 56

WE take this opportunity to announce to hospital superintendents and administrators the news that we are now in a position to furnish, in any quantity, a complete line of

HOSPITAL FURNITURE
and BEDSTEADS

Our new plant, operated under personal supervision of men of long experience in the manufacture of metal furniture, enables us to stand behind the quality of our products.

Call us in to figure on your furniture requirements whether large or small.

We also handle general hospital supplies of every nature, including rubber goods, enamelware, glassware and textiles—all the products of reliable manufacturers.

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705 N. 12th Street **Philadelphia, Pa.**

Consult the 1920 Year Book for Catalog information.

in the hospital; in four more a dental service was in the process of establishment; in twelve more it was being planned, and in two more it was hoped for. Thus dental service was either definitely established or well under way in more than one-third of the 282 larger general hospitals of the United States.

In 46 of these hospitals, dental service is recognized as of departmental rank, with assigned beds in some instances and in others with use of beds as needed. In 32 of the 89, dental service is not recognized as a department, but is organized for purposes of consultation and diagnosis. In 11 of the 89 hospitals, dental work includes offering dental treatment to patients but is not recognized as a general department of the hospital.

Of the 89 hospitals with dental service, 41 maintained dental work for their ward patients, but had no general dental clinic. Seventeen of the 89 hospitals had no dispensary clinics of any kind, but of the remaining 72 which had some out-patient department, 48 had a dental clinic as part thereof.

Most of these clinics were for dental treatment as well as for diagnosis, only five being limited to diagnosis only.

The great pressure for dental service is illustrated by the fact that a large number of these hospitals have found it necessary to limit their dental clinic for the use of patients referred from other parts of the hospital or dispensary.

From the answers to the general questions of our inquiry, it may be said that all the leading hospitals, as reported by their superintendents, recognized the desirability of dental service. The only question that existed was as to the details of its organization and the extent to which dental work should be carried out, owing to the expense and to the risk that the hospital or dispensary would be swamped if a dental clinic were opened up for general community purposes.

A Dentist on the Hospital Staff

On the basis of this survey and of studies of dental work in various hospitals made in connection with other surveys, certain points or principles might well be set down.

(1) A dentist competent as a dental diagnostician should be recognized with adequate rank on the staff of the hospital, and should be given the necessary facilities, such as access to the x-ray and to beds when necessary.

(2) The primary responsibility of the hospital in dental care is the dental diagnosis of patients whose mouth conditions are involved as a factor in the disease for which the hospital accepted these cases, and for whom dental treatment is necessary in order that the hospital's medical or surgical work shall attain satisfactory results. In other words, a hospital cannot carry out adequate diagnosis and treatment without undertaking dental diagnosis, and in some instances dental treatment also.

(3) A routine dental examination of hospital cases should be included as part of the physical examination.

(4) Hospitals maintaining out-patient departments should include a dental clinic for treatment purposes as part of this out-patient department, unless by some definite affiliation with another accessible dental clinic, the necessary dental care of its patients can be assured.

Hospitals Should Limit Dental Service

(5) The service of a dental clinic as part of the hospital out-patient department must ordinarily be limited in order to avoid over-crowding. Patients should be accepted for treatment in the following order:

a. Patients already received by the hospital or dispensary, whose mouth conditions are involved in a general medical or surgical condition which the hospital or dispensary has diagnosed, and for which it has assumed responsibility for treatment. To give dental care to these patients, or to arrange for their care by definite reference and follow-up to some other institution is a responsibility which every hospital ought to meet.

b. Patients referred to the dental clinic from other medical or community agencies (such as a doctor or a visiting nursing organization) with the indication that the dental conditions are involved in the general condition of the patient.

c. Relief of pain and other emergency dental work for patients not otherwise connected with the hospital, but accepted merely as emergency cases.

d. Other patients accepted up to whatever number may be consistent with the facilities. So far as possible, this restriction should be on a district basis.

(6) Dental organization in the hospital.

a. The dentist recognized as head of the dental service of the hospital should be in charge of the organization of its dental work, including the out-patient clinic.

b. Assistant dentists are desirable as visiting members of the staff of the dental clinic.

c. A dental intern is desirable, as a member of the staff of the hospital. His work should be confined to assisting in the therapeutic work of the out-patient department. He should also be given opportunity to work in the diagnostic service with the chief of the hospital dental department, in order that his year of internship shall be a year of advanced dental education in both curative and diagnostic work. The supply of dental interns is inadequate, but the trend of dental education will stimulate young graduates to take a hospital year, and the increasing demand for dental service in hospitals may be expected to increase also the facilities which hospitals will offer to dental graduates.

d. The dental hygienist is a desirable member of the staff of the dental clinic, and as an agent for cleaning the teeth of bed patients in the hospital.

e. Salaries for visiting dentists are generally necessary.

f. The dental clinic should charge fees covering cost of treatment, remitted, however, if the patients are unable to pay.

Prophylactic Work Should Be Free

(7) The following financial policies are reasonable in the maintenance of organized dental service:

a. Prophylactic work for children should be free and open to all children of school ages on the same terms as is public education.

b. With respect to the cost of this service, it should be borne in mind that the estimated cost of tooth cleaning and of instruction in mouth hygiene to children on a large scale is less than 5 per cent of the usual per capita cost of school education, and is a measure which will make more efficient the other 95 per cent expended.

c. For dental care other than prophylaxis, a charge should be made in the clinic, including an admission fee and additional charges for materials used for fillings, anesthesia, and other purposes; these fees being remitted when necessary.

Adv. page 58

Illustration of 734-1916 Hospital and Institution Bed, with Adjustable Irrigating Standard and Head Rest.

The Modern Hospital Bed

FOR use in ward or private room, this three-piece bed has proved itself to be invaluable. Of sanitary chill-less construction, finished in white enamel and mounted on detachable wheel-casters, it is the height of perfection in hospital bed construction.

The ideal link sagless fabric that is used for the spring on this bed gives the body just the correct amount of support necessary for comfortable sleep. The headrest and irrigating standard attachments are easily attached and are most convenient.

But this is only a part of the hospital service equipment Salisbury & Satterlee have to offer you. Write us for further information on S. & S. hospital equipment. Ask for the new catalog.

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METAL BEDS–SPRINGS–MATTRESSES
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S&S 1877 SLUMBER SERVICE

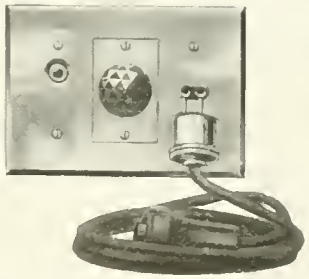
Corner of Ward Showing Installation of Bryant Silent Call Hospital Signal Devices

The Patient Presses a Button

Instantly signal lights at various parts of the building show the nurses exactly where their services are wanted.

The button operates with the lightest touch but cannot function unless intentionally pushed. A call made by a patient must be answered before the signals can be erased. The patient is sure to receive attention.

No. 14 Ward Calling Station is illustrated below.



When the button is pushed a magnet operates the control switch which connects the various signal circuits. In wards a red bull's eye indicates the patient who calls. The nurse resets the switch and extinguishes the signals by pressing the resetting button.

This is the first of a series of advertisements in Modern Hospital explaining the Operation of Bryant Silent Call Hospital Signal Devices. Next month the new Pull Toggle Control Switch will be described. In the meantime, send for the 36-page catalog which explains the system in detail.

THE BRYANT ELECTRIC COMPANY
BRIDGEPORT, CONN.
NEW YORK CHICAGO SAN FRANCISCO

YB

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Hints to Hospital Superintendents

SAVING TIME IN LINEN TRANSPORTATION

Most hospitals feel that they have taken a step forward in efficiency when they establish a central linen room. But here is a further advance suggested in its elimination. The soiled linen is sent, as before, direct to the laundry, but when it has been washed, instead of being piled into baskets and taken to the linen room, there to be sorted and placed on shelves, and then transferred from the shelves to the carriers and thence to the wards, a much simpler method has been adopted. The linen is taken directly from the laundry machines to sorting shelves in the laundry, and from these shelves it is placed in baskets for the various wards and delivered to them direct. Savings are effected in time for transportation as well as in sorting and filling the orders. These last processes may be done by the head laundress, thus eliminating the position of head of the linen room.

PUT UP PLENTY OF GUIDING SIGNS

If, because your building is an old one not adapted to modern procedures, your social service department or some other department which must be visited by entering patients is only reached by devious and winding ways, see that there are plenty of guiding signs. So often bewildered patients wander about the hospital in a vain attempt to locate the department to which they were sent. They bother the personnel of the institution and wear themselves out with their efforts. Then, too, in the case of foreigners it might be well to have signs on the order of the well known English signboard, "If you can't read English, inquire here."

"LEST WE FORGET"

The remark was overheard in a hospital of very good standing, "O, that is too bad, but your nurse forgot to bring your medicine, didn't she?" Forgot? Evidently, she did. Fortunately the forgotten dose made no great difference in the welfare of the patient but suppose the nurse had forgotten the necessary hypodermic to keep the patient alive. "Forgetting" should be a criminal offense in a hospital. Not something to be mildly deplored. Military discipline is as much needed here as when the enemy is in the next trench.

Another thing noticed in the same hospital was that the nurse often had to ask the patient whether or not he had had the prescribed eggnogg or milk that morning. It seemed that the patient was his own keeper. If he said no, someone was dispatched to get the drink though it might then be an hour or so late. There seemed to be no coordination or organization in the matter. Whose business was it to see that the patient in Room 14 had his drink at eleven? No one seemed to know, at least if they did they kept it a secret.

STUDENTS TAUGHT BY STUDENTS

Are your student nurses taught certain nursing procedures by other students? It is true that in some hospitals this method of the blind leading the blind is used to some extent. Of course the teaching staff of the school may be entirely inadequate for its work, yet this should not be an excuse for not giving at least one or two demonstrations, before the student is left to perform the service under the guidance of only another student.

FIRST IMPRESSIONS AGAIN

Perhaps you think that the "welcoming tone" of the hospital is a bit overemphasized. But it could not be, it is so very important. First impressions mean much to all of us—more than ever to the sick. Drill your attendants in the habit of looking pleasant and jumping to take the newcomers suitcase, or do some little service. Impress the clerk at the information desk with the importance of a smile accompanied by painstaking service. These things create the first impression of your hospital.

HAVE LIGHT WHICH THE PATIENT CAN ADJUST

A bedside light which the patient himself can adjust is an excellent thing in a hospital. Perhaps a standing floor lamp which may be turned in any direction or bent or straightened would be the best kind to have. To say nothing of the extra labor of the nurse, it gives the patient a helpless feeling to have to ring for someone else to turn on or adjust his light. You cannot tell how great the psychological effect of such things may be. In any case, it is worth taking into consideration.

HAVE YOU PLENTY OF SWITCHBOARD OPERATORS?

Have you ever gone out of your own hospital and anonymously called up by telephone asking for information about or to speak to one of the patients? If not it would be an illuminating experience. To the uninitiated the hospital is a place of great speed and dispatch—like a fire department—where in an emergency things can be done and had in an incredibly short time. It shatters this illusion to be kept sitting at the phone for three to five minutes waiting for the proper connection. Sometimes, quite often in fact, we have been left high and dry speaking persuasive words to an entirely deaf ear at the other end of the wire. Perhaps the operator has gone out to lunch, but she might at least have warned us that she was going. This department of the hospital seems quite often to be very short handed. Plenty of operators should be provided, and they should be carefully trained and impressed with the extreme importance of their position.

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Barnes Hospital, St. Louis

WITHOUT doubt this is one of the best equipped, most up-to-date hospitals in the United States. The fact that it is equipped with Smith & Davis Hospital Furniture speaks volumes for the high character of Smith & Davis products. The endorsement of such a progressive institution is a safe guide for other hospitals and sanitariums in the selection of Hospital Beds and Cribs, Maternity Bedsteads, Bedside Tables, Screens, Irrigators, Utensil Racks, Bed Trucks, Conveyers, Stretchers, etc.

We furnish complete equipments for hospitals, sanitariums, college dormitories and similar institutions. Suggestions, blue prints and prices on request. Special price reductions on quantity orders.

Or, if you have in mind something different in beds or furniture, to be specially built according to your own specifications, we will cordially co-operate with you in its designing and production.

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Queries and Answers

MINIMUM OF LABORATORY WORK

To the Editor of The Modern Hospital:

What is the minimum laboratory work that every hospital should be prepared to carry on? TECHNICIAN.

Urinalysis, blood examinations, as white and red cell counts and hemoglobin; smears for bacteria; examination of spinal fluid; examination of stomach contents; examination of feces; preservation of tissues for pathological investigation elsewhere.

TEN MONTHS' COURSE FOR LABORATORY WORK

To the Editor of The Modern Hospital:

Could a graduate nurse acquire sufficient knowledge and training anywhere in eight or ten months to fit her to carry on the laboratory, x-ray, and medical record work necessary for a hospital of less than one hundred beds? GRADUATE NURSE.

Yes, some hospitals offer such courses. For example, the Vancouver General Hospital offers a course of ten months, apportioned as follows: Medical records, two months; x-ray, four months; laboratory, four months. This would give sufficient knowledge to undertake the work in a hospital of one hundred beds or less. This course, we understand, is at present limited to candidates from British Columbia.

ROUSING INTEREST IN STANDARDIZATION

To the Editor of The Modern Hospital:

How can we increase the interest of the profession and the community in hospital standardization? A HOSPITAL ASSOCIATION.

Keep hospital standardization constantly before everyone in its actual application. Apply it most strictly in the hospital and use every occasion to carry it home to both the doctors and the people in the community. The placing of literature in their hands from time to time will help to get the interest worked up. One of the best methods is to have a standardization committee consisting of professional and lay members.

MONTHLY MEDICAL REPORT TO BOARD OF DIRECTORS

To the Editor of The Modern Hospital:

Should a monthly medical report be sent to the board of directors or trustees and, if so, of what should it consist? CHIEF OF STAFF.

Yes. A monthly report to the board of directors or trustees should be sent and should indicate the following:

(a) Volume of work done during the month in each department.
(b) Results obtained.
(c) Special consideration of:
  (1) Unimproved,
  (2) Deaths,
  (3) Infections or untoward results.
(d) Investigations made:
  (1) Professional care of patients,
  (2) Administration problems and complaints.
(e) Recommendations.

CONNECTION BETWEEN STERILIZING AND OPERATING ROOM

To the Editor of The Modern Hospital:

Should a sterilizing room be connected directly with the operating room? A SURGEON.

A direct connection between sterilizing room and operating room is not advisable because the steam from the sterilizing room affects the instruments and creates a condensation on the walls of the operating room which is difficult to remove.

SHOULD THE STAFF LIVE OUTSIDE THE HOSPITAL?

To the Editor of The Modern Hospital:

Should the staff, other than nurses, live in or out of the hospital, and which is the most economical for the hospital? BOARD OF TRUSTEES,

Some hospitals find it more desirable to have all their staff, other than nurses, live out side of the hospital, thus relieving them of a great deal of extra equipment and trouble. However, it is generally conceded that it is more economical to keep the entire staff living in. This is impossible in many hospitals, owing to lack of accommodation.

CREAM OR BUFF SHADE BEST COLOR FOR HOSPITALS

To the Editor of The Modern Hospital:

What is the most desirable color scheme for walls and ceilings in a hospital? ARCHITECT.

The most desirable color scheme for walls and ceilings in a hospital appears to be a cream or buff shade or light green. In places where there are many dark or rainy days the light buff or cream for walls and ceilings is the most generally used.

VISITING HOURS FOR WAGE EARNER

To the Editor of The Modern Hospital:

Is it just to the head and wage earner of a family to be excluded from the hospital because he cannot call during visiting hours? SUPERINTENDENT OF NURSES.

It is hardly fair that the wage earner should not be allowed to visit members of his family when his business prevents him from observing regular visiting hours. In some hospitals a good plan is in force which allows such persons to come two evenings each week, possibly between 7 and 7:30.

Adv. page 62

THE DIAGNOSIS OF SYPHILIS

in its Primary Stage is Essential for an Immediate Cure

In the early stages of the disease, Wassermann tests are not always positive and they must be supplemented by microscopic examinations. The most simple and easy method of microscopic examination is with an up-to-date microscope fitted with a substage dark-field illuminator. We recommend two improved types of these instruments.

The U. S. Army Medical School Model Dark-Field Illuminator was designed in cooperation with Major G. B. Foster, Jr., and other officers of the Medical Corp at the U. S. Army Medical School to obtain a compact instrument independent of accessory lamps with which difficulty is usually experienced in getting the proper illumination. This has been accomplished by mounting a low voltage Mazda lamp and condensing lens in a telescoping sleeve on the under side of the usual substage dark-field. This construction facilitates the exact focusing of the beam of light for properly illuminating the system. Centering screws are provided for aligning the lamp and dark-field with the axis of the optical system of the microscope on which it is used. A diaphragm is provided for use with a 1.8 mm oil-immersion objective. The necessary electric current for the Mazda lamp may be obtained either from dry batteries, storage batteries or from the lighting circuit by using a resistance. When ordering give the name of the maker, type and number of the microscope on which the dark-field will be used.

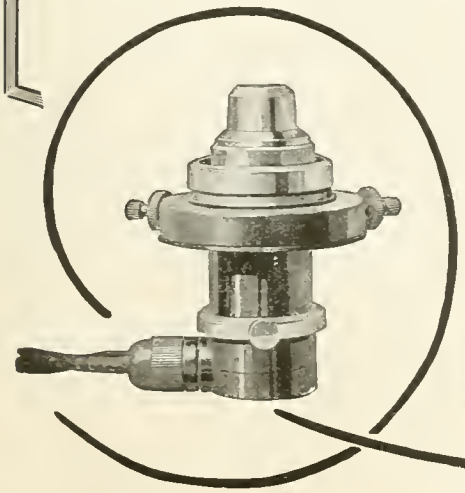
8645. **ILLUMINATOR, Dark-field,** as described above. Complete with diaphragm for oil-immersion objective, lamp cord, Edison socket and extra 6 volt Mazda lamp, in plush lined wooden case $35.00

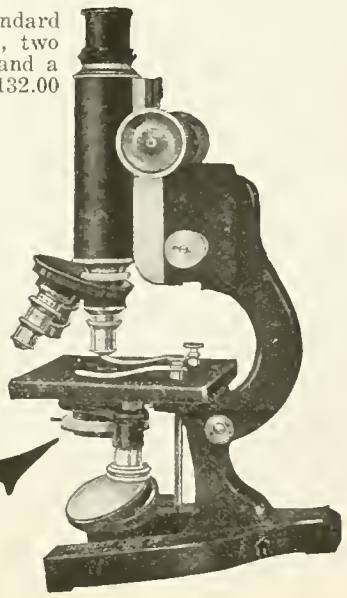
8646. **RESISTANCE,** to reduce lighting voltage A.C. or D.C. to 6 volts:

No.	A.	C.B.
For volts	110	220
Each	$6.00	$8.00

The Spencer 44H Microscope is a microscope well adapted to meet the requirements of hospital and general medical laboratories and is especially recommended for use with the No. 8645 Dark-Field Illuminator. It is a very strong but graceful microscope, fitted with a patented side fine adjustment possessing many exclusive features. The principle feature is the construction of the solid steel fine adjustment screw, which has 20 of its 34 threads engaged even at the limit of its motion. This construction distributes the wear, lengthens the life of the most vital part of the instrument and enables the operator to work with an ease not obtained with other types of fine adjustment. The direction in focusing is the same with both the fine and coarse adjustments. One revolution moves the tube 0.2mm. The body tube is standard, taking standard objectives and oculars. The stage is 112x108mm, and is completely covered with genuine vulcanite rubber, vulcanized directly to the stage plate. The sub-stage is of the standard quick-screw form.

8532. **MICROSCOPE, Spencer 44H,** as described above. Complete with standard body tube, triple nose-piece, three objectives, including a 1.8mm oil-immersion, two oculars, N. A. 1.20 Abbe condenser mounted in the quick-screw form sub-stage, and a hardwood cabinet with lock and key..... $132.00





A ten per cent discount will be allowed to all Hospitals or Educational Institutions on the above equipment.

For further information on the above items write for bulletins No. 32MH, 96MH, and 96AMH.

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LABORATORY SUPPLIES
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460 E. Ohio St., Chicago, U.S.A.

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Consult the 1920 Year Book for Catalog information.

Book Reviews and Current Hospital Literature

A PRIMER FOR DIABETIC PATIENTS

By Russell M. Wilder, Ph.D., M.D.; Mary A. Foley, Dietitian; and Daisy Ellithorpe, Dietitian, The Mayo Clinic.[1]

Dr. Russell Wilder and two dietitians, Mary Foley and Daisy Ellithorpe of the Mayo Clinic, have prepared this Primer for their patients. The material in mimeographed form has been used successfully at the Mayo Clinic for some time. It has been printed in book form in order to more satisfactorily meet the demand for it. This Primer was designed for use as a supplement to Dr. Joslin's Diabetic Manual, the instruction being given in more detail. For example, the chapters on Weights and Measures, Food as Energy, and Urine Testing explain, as well as state facts in such a way that the patient with no information on these subjects can easily follow them. A good selection of menus and recipes is given, with discussion of some food materials used.

REVIEW OF THE YEAR-BOOK

The American Year Book of Anesthesia and Analgesia, 1917-1918. (Copyrighted January, 1921.) F. H. McMechan, M.D., Editor. Large Quarto, Bound in Art Buckram and Printed on Natural Tint Paper, 471 Text Pages, 175 Illustrations. Containing a Cumulative Index of the Pertinent Literature for 1917-1918 and Contributions by 84 Eminent Authorities.[2]

The American Year Book of Anesthesia and Analgesia, covering the advances in these subjects during 1917-1918, is just at hand in its de luxe format, making as much of a typographical as a scientific appeal. Delayed in publication by the World War, it contains those methods of anesthesia and analgesia introduced to expedite military surgery, which are to find a place for themselves in civilian practise for the benefit of all concerned.

Again the editor of the Year Book has tried to make it appeal to all the progressive members of the allied professions and specialties who, in any way, are vitally interested in current advances in the science and art of anesthesia and analgesia.

The Year Book, as a cumulative encyclopedia, provides the anesthetist, specialist, surgeon, dentist, research worker, and hospital superintendent with those special advances that meet their individual requirements.

Fundamental studies in the pharmaco-physiopathology of anesthesia and analgesia, of exceptional merit, have been included, and as many of them have a direct bearing on the clinical handling of patients submitting to operations under narcosis, they are doubly significant and valuable.

All pertinent phases of the science and practice of anesthesia and analgesia during 1917-1918 have been covered in collated papers and researches from the most prominent international authorities, and the Year Book is again a comprehensive and exhaustive postgraduate course. To those interested it is not a luxury but an everyday necessity as a reference volume.

Aside from series of contributions on complicating and safety factors of anesthesia, acidosis, blood changes, blood pressure variations, pharmaco-physiopathological studies both in general and local anesthesia, methods of technic, especially those developed in war surgery and the newer methods of local analgesia in surgery, dentistry, and the specialties, the Year Book contains a cumulative index of the pertinent literature for 1917-1918, which is invaluable to anyone making a study of any phases of these subjects and needing the necessary bibliography for reference or teaching.

1. W. B. Saunders Company, Philadelphia, Pa.
2. Surgery Publishing Co., 15 East 26th St., New York City.

EATING TO LIVE LONG

By William Henry Porter, M.D. 243 pages.[1]

Seldom have we seen a book containing so much that is commendable and so much that we cannot commend combined in one small volume. The title of the book and the headings of each chapter would indicate that a subject of very general interest is discussed in a popular way, and to a great extent this is true, though there is considerable material included in various chapters which is evidently written for the physician. Yet a great deal of this material is not in accord with the more widely accepted belief of today. Dr. Porter condemns the use of fruit, especially at meal time, and advocates more liberal use of meat, a practice which would meet the approval of only a small minority of medical men and nutrition workers; he decries the use of oatmeal because only a small percentage of it is used by the body, in another chapter he speaks of the need of "roughage" in the diet. Many good sound principles are advocated in forceful language, it is to be regretted that the force of the text is lessened by what would seem to be an opportunity for the author to rebel against the prevalent teachings in nutrition and dietotherapy.

An appeal to school children in all parts of the United States to build chairs and tables to be used in re-equipping the schools in the devastated areas of France and Belgium has been issued by the Junior Department of the Red Cross. French schools are handicapped by a deplorable shortage of equipment that cannot be purchased in France. An organization has been formed in France through which schools outside the devastated area have adopted schools in the war zone, for the purpose of providing equipment, but so far only half the schools have been taken care of.

1. The Reilly & Lee Co., Chicago.

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The Modern hospital

Biological
& Medical
Serials

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